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HEALTH PROMOTION, ORGANIZATIONAL EMPOWERMENT, AND HEALTH EQUITY: A CASE STUDY

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HEALTH PROMOTION, ORGANIZATIONAL EMPOWERMENT, AND HEALTH EQUITY: A CASE STUDY

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Abstract

This study aims to explore the understandings and practices of empowerment from the perspective of professionals working in a Canadian health promotion organization whose mandate is to reduce health inequities. Data were collected from two focus group interviews with eleven members of the organization as well as from nine annual reports. A critical discourse analysis approach was utilized to analyze the data. Analysis suggests that the participants have divergent conceptualizations of empowerment and these understandings emphasize behaviorist notions of empowerment. The organization's practices of empowerment were also in line with behaviorist approaches to health promotion. The participants of this study gave little attention to power relation issues and this fact diverges from health promotion's ultimate goal of changing the social, economic, and environmental status to decrease health inequities. This study sheds light on the necessity of professionals to continuously reflect on their discourses in order to advance their practices.

Keywords: health promotion, empowerment, organizational empowerment, health equity, case study, critical discourse analysis

Dedication

I dedicate this thesis to several special people:

- To my parents (Ena and Luiz): their unconditional love and support provided me the foundation to pursue this degree;
- To my sisters (Ju and Gabi): they helped me to see what is important in life: love and friendship. This dedication is also extended to my nephews (Marcelo and Luiza) and brothers-in-law (Ray and Márcio);
- To Arthur: his support and love is also central to my life;
- To my many best friends: Carol Melo, Cristiana, Douglas, Érica, Gerlane, Leila, Líbia, Lilian Karine, Maria, Michelle, and Shirlene. The time I spent abroad just helped to strengthen our friendship;
- Finally, to all the friends and partners from the Brazilian medical students' movement (DA Josué de Castro and DENEM). Now I see how important to my political and social views were the days and nights of endless meetings, heated debates, and long travels around Brazil and abroad.

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I also want to thank the participants of the study and specially the gatekeepers whose names, for issues of confidentiality, I cannot disclose. I greatly appreciate their time and commitment to the study.

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List of Abbreviations

CCHPR = Canadian Consortium for Health Promotion Research

CE = Community empowerment

CDA = Critical discourse analysis

DA = Discourse analysis

IUHPE = International Union of Health Promotion and Education

OE = Organizational empowerment

PAHO = Pan American Health Organization

PE = Psychological (or Individual) empowerment

PHAC = Public Health Agency of Canada

UWO = University of Western Ontario

WHO = World Health Organization

Chapter 1: Introduction

This thesis presents the results of a qualitative case study that explored the understanding and practices of empowerment from the perspective of professionals working in a health promotion organization which aims to reduce health inequities. Two focus groups with staff and board members as well as an analysis of the organization's annual reports provided the data set for the analysis of the organization members' understanding and practice of empowerment. A critical discourse analysis approach was adopted to examine the participants' and annual reports' narratives of empowerment. In what follows, I introduce the central topics of this study – health equity, health promotion, and empowerment theory – and present the study objectives and research questions.

The negative effect of poor social conditions and social inequities on the health of individuals and population groups has been reported by researchers and public health agencies (Hofrichter, 2003; Krasnik & Rasmussen, 2002; Pan American Health Organization [PAHO], 2007). For example, according to the Public Health Agency of Canada (PHAC, 2003),

> The evidence indicates that the key factors which influence population health are: income and social status; social support networks; education; employment/ working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture. (para. 4)

Bégin (2010) emphasized that "we have now accumulated indisputable evidence that '*social injustice is killing people on a grand scale*'" (p. 5, italics in original). As such, it becomes evident that the reduction of health inequities should be a central goal of the health and health promotion sectors (Bambas & Casas, 2003; International Union of

Health Promotion and Education [IUHPE], 2010; Rifkin, 2003). Although it is recognized that health is not the only sector responsible for improving social, economic, and environmental conditions that promote health (Marmot, 2005), scholars and professionals from the health promotion field have incorporated the goal of reduction in health inequity as a way to promote health (M. Davies & Adshead, 2009; S. B. C. Freire, Manoncourt, & Mukhopadhyay, 2009).

The Ottawa Charter for Health Promotion (World Health Organization [WHO], 1986) provides the ground for promoting health equity. This charter defines health promotion as "the process of enabling people to increase control over, and to improve, their health" (para. 1). It also details the prerequisites for health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. From these prerequisites, it is evident that social, political, economic, and environmental structures are central to the promotion of good health around the world. It follows that governments, health and related sectors, private and public organizations, communities, professionals, and individuals should work to ensure that the prerequisites for health are satisfied to enable social, political, economic, and environmental changes that promote health.

Rather than developing programs to address social, political, economic, and environmental constraints on the promotion of health, in general, many health promotion programs are focused on disease prevention and behavioral change approaches (P. Carey, 2000; Laverack, 2004; Wallerstein, 1993). According to Laverack (2006) and Raphael (2003a), evidence demonstrates that disease prevention and behavioral change approaches do not meet the needs of communities. Laverack (2009) has stated these types of approaches limit the health promotion programs by addressing just one part of the process of improving citizens' health. A number of

scholars have recently suggested that empowerment-based interventions address the shortcomings of disease prevention and behavioral change approaches (Laverack, 2006; Ratna & Rifkin, 2007; Wallerstein, 2006). In a more emphatic way, Marmot (2009) affirmed, "at the centre of what we are trying to achieve [closing the health gap in a generation] is empowerment of individuals, of communities and indeed of whole countries" (p. 23).

Concepts of empowerment have been in vogue in the health promotion literature for many years (Laverack, 2006; Rissel, 1994; Simons-Morton & Crump, 1996). Labonte (Bernstein et al., 1994) claimed that "empowerment is a process by which groups with less objective forms of power reach more equitable exercise and distribution of those forms of power..." (p. 284). The author goes on to add that objective forms of power are resources (money, supplies, or goods) and social status (political legitimacy, direct decision-making authority, and access to political influence). Friel, Bell, Houweling, and Marmot (2009) concurred with Labonte when they wrote, "By empowerment we mean having enough physical and financial resources (material empowerment), control (psychological empowerment) and voice (political empowerment) to have the freedom to live healthy lives" (p. 9).

Empowerment theory has three basics levels of analysis: individual, organizational, and community (Zimmerman, 2000). Each level has its characteristics and processes. Although this study examines the three basic analysis of empowerment, much of the focus is on organizational empowerment (OE) processes. In light of this overview, in what follows, I provide an in-depth analysis of the topics of this thesis and outline the significance of this study.

Background and Significance

In this section, I provide an overview of the central topics of this study – health promotion, health equity, and empowerment concepts – in order to outline the significance of this study. I first discuss health and health promotion, followed by an examination of health equity from a health promotion perspective. Finally, I provide an overview of empowerment concepts, with a focus on organizational empowerment.

Perspectives on health and health promotion. The most commonly adopted definition of health is a "complete state of physical, psychological, and social wellbeing, not merely absence of disease or illness" (WHO, 1948, p. 1). Despite critiques of this definition (Tones & Tilford, 2001; Buchanan, 2000), the WHO's definition of health is relevant because it includes lifestyle, medical, psychological, and social dimensions of health (Robertson & Minkler, 1994). In addition, Bambas and Casas (2003), de Vos et al. (2009), and Turiano and Smith (2008) acknowledge that health is a human right. Health as a human right implies a political stance on the concept of health because governments and social agencies are responsible for enabling access not only to healthcare but to social, economic, and environmental conditions that enable people's health (Bambas & Casas, 2003; IUHPE, 2010; Tones & Green, 2004; Turiano & Smith, 2008).

By enumerating the prerequisites for health (e.g., peace, income, social justice and equity), the Ottawa Charter for Health Promotion (WHO, 1986) brought to light a radical approach to health promotion when it highlighted the importance of the social and political change required to improve people's health (Tones, 1998b). Accordingly, social and political ideologies play a central role in the health sector (Collins & Hayes, 2007; Hofrichter, 2003; Tones & Green, 2004). Thus, health promotion interventions

change depending on the ideology of health promoters, health organizations, funding agencies, and governments that support, develop, and apply those interventions.

Medical, behavioral, and socio-ecological are the three general approaches to health promotion (Labonte, 1993) that are also ideologically driven (Raphael, 2003b) and that have been recognized as important for the development of health promotion interventions (Israel, Checkoway, Schulz, & Zimmerman, 1994; Labonte, Woodard, Chad, & Laverack, 2002). While the medical approach focus on the prevention of diseases (e.g., cardiovascular diseases and cancer), the behavioral approach concerns lifestyle and personal attitudes (e.g., smoking and physical activity) (Labonte, 1993, 1994). The socio-ecological approach goes beyond behavior change and disease prevention to emphasize the social, political, economic, and environmental features necessary to promote health at a societal level (International Union for Health Promotion and Education & Canadian Consortium for Health Promotion Research [IUHPE & CCHPR], 2007). A report by the Health Council of Canada (Health Council of Canada, 2010) corroborate with such a claim:

> It's not that lifestyle choices such as good nutrition and exercise don't matter – they do. But a substantial body of evidence has shown that the broader determinants of health have an impact on our lives that is just as strong, if not stronger. (p. 4)

Yet, the medical and behavioral ideologies are hegemonic with respect to health interventions developed by public and private agencies (P. Carey, 2000; Guldan, 1996; Laverack, 2009; Raphael, 2003b). As a result, many health promotion interventions are limited to prevent disease and change behaviors with little attention to the socio, political, economic, and environmental determinants of health (Laverack, 2007; Raphael, 2003b).

Health inequities from a health promotion perspective. Many scholars have been championing the reduction of health disparities as a way to promote health (Bambas & Casas, 2003; IUHPE, 2010; Rifkin, 2003). As a result, health equity has been on the agenda of researchers and health authorities in the health promotion field for many years (Kjellstrom, Mercado, Sami, Havemann, & Iwao, 2007). The definition of health inequities, according to Braveman and Gruskin (2003), is:

> systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/ disadvantage – that is, wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged … at further disadvantage with respect to their health. (p. 254)

Socio-economic factors are the most cited reason for disparities in health (WHO, 1978), but culture, gender, age, religion, ethnic group, and geographic location also serve to explain such differences in health status (Braveman & Gruskin, 2003; Whitehead & Dahlgren, 2006).

Working toward the resolution of health inequities is a huge challenge for the global community (Kjellstrom et al., 2007; O'Brien, 2009) and requires political change within all sector of the society (Braveman & Tarimo, 2002; Raphael, 2003b). Thus, governments, organizations, communities, and professionals should foster the development of health interventions that address those required changes to promote health.

Empowerment theory from a health promotion perspective. Concepts of empowerment have been used to address health inequity issues among population groups (Friel et al., 2009; Wallerstein, 2002). A report on healthy equity by the WHO (Commission on Social Determinants of Health, 2008) recommended that political

empowerment of citizens and communities are central to foster equity in health. As such, health promotion scholars and practitioners have been championing empowerment strategies as a way to promote health and reduce health inequities (Labonte, 1993; Laverack, 2006; Wallerstein, 2002).

Empowerment strategies can be analyzed at three basic levels: individual, organizational, and community (Zimmerman, 2000). Individual (or psychological) empowerment (PE) is "the process by which individuals gain control over their lives" (Spreitzer, 1995, p. 602). Even though PE is recognized as the "mediator of the relationship between social structure and behavior" (Spreitzer, 1995, p. 602), individual empowerment is not consistent with the major goal of the social-ecological approach to health promotion because PE transfers responsibility onto the individual for his or her health and does not consider all the dimensions of health (Laverack, 2004). Freire and Shor (1986) support this idea when they asserted that an empowered person is a necessary condition for the process of social transformation, but it is not sufficient.

The second level of empowerment is community empowerment (CE) which is "a social action process that promotes participation of people, who are in position of perceived and actual powerlessness, toward goals of increased individual and community decision-making and control, equity of resources, and improved quality of life" (Wallerstein, 1993, p. 219). This definition of community empowerment includes the complex social interaction that defines health and affirms that empowerment is essential for marginalized people to gain control over their health. However, the community empowerment fails to provide organizational level constructs that influence the development of empowerment strategies (Zimmerman, 2000).

The third level of analysis is organizational empowerment (OE). OE includes "organizational efforts that generate PE among members" (Peterson & Zimmerman,

2004, p. 130) and the need of the organization be involved in societal-level change to achieve success in health interventions (Zimmerman, 2000). Different from the other levels of empowerment, OE explores the dynamics of empowerment at both individual and collective levels because it concerns individual processes of empowerment among organizations' members as well as the influence of organizations in the larger social environment of which they are part. Many academics claim that community and organizational empowerment are strategies that public and private health agencies should use to address health inequities and social disparities (Pilisuk, McAllister, Rothman, & Larin, 2005; Wallerstein, 2006).

P. Carey (2000) and Laverack (2004) suggest that health promotion organizations are generally resistant to change their practices to more progressive approaches, towards empowerment. Sources of organizational resistance to adopt empowerment strategies include:

- a lack of a shared understanding about the importance of the relationship between power, empowerment, and health within health promotion organizations (Laverack, 2004);
- the hegemonic effect of the medical and behavioral model in the health field that over-emphasize the individual rather than the social collective (Rappaport, 1981; Tones & Tilford, 2001; Wallerstein & Freudenberg, 1998); and
- the negative influence of funding agencies or employment conditions on community organizations (G. E. Carey & Braunack-Mayer, 2009; Wallerstein & Freudenberg, 1998).

According to Peterson and Zimmerman (2004), a shared understanding of empowerment among health care providers is essential to the development and sustainability of interventions seeking community empowerment. A common

understanding also determines the influence that organizations want to make in the health system – how empowered the organization want to be for enabling social, economic, political, and environmental changes which are necessary to promote health (P. Carey, 2000). Seeking to contribute to the development of empowered organizations with a mandate to reduce health inequities; this study intends to explore a health promotion organization's understandings and practices of empowerment.

Statement of the Problem, Study Purpose, and Research Questions

Despite the growing awareness of the positive health outcomes that empowerment strategies may provide (Wallerstein, 2006), it is suggested that health organizations resist to change their practices to more progressive approaches (Laverack, 2004). One of the sources of organizational resistance includes a lack of an understanding about the relationship between power, empowerment, and health within a health promotion program (Laverack, 2004). More importantly, health organizations should share a common understanding of empowerment in order to become an empowered organization (Peterson & Zimmerman, 2004).

The objective of this case study is to critically analyze the conceptualization of empowerment among professionals in a health organization that engages in an empowerment relationship with communities, organizations, and broad social structures to address health inequities.

The research questions which guide this study are:

1. What is the understanding(s) of power and empowerment among professionals in a single health organization?
2. How are the concepts of empowerment reflected in professionals' practices?

In order to investigate the research questions and to fulfill the aims of this study, I performed a critical discourse analysis of two focus groups and organization's

documents. The first focus group was comprised by eight staff members, while the second group was constituted by three members of the board of directors. The documents analyzed included nine annual reports developed by the organization's members.

Organization of the Thesis

This thesis consists of five chapters. In the next chapter, I report a review of relevant literature on health promotion, health equity, and empowerment. In Chapter 3, I outline the methodology and methods used and examine my position as a researcher. I present the results of the critical discourse analysis in Chapter 4. In Chapter 5, I discuss this discourse analysis in relation to the current debate in the health promotion, health equity, and organizational empowerment literature. This last chapter also presents the strengths and limitations of the study and recommends directions for future research.

Chapter 2: Literature Review

Rationale

The objective of this selected literature review is to explore the "ongoing dialogue in the literature" about health promotion, health inequities, and empowerment (Creswell, 2003, p. 30). It aims to understand how the concepts of empowerment have been applied within the health promotion context in an attempt to address health inequities. This review of the relevant literature on health promotion, empowerment, and health equity will also locate the proposed study within the large body of the literature.

Methods

To conduct this literature review, I adopted Creswell's (2003) recommendations. He suggests seven steps, of which I utilized six: (a) identification of key words; (b) literature search; (c) set the priority on the search; (d) design of a literature map; (e) data analysis; and (f) presentation of the findings and report writing. Some suggestions by Whittemore and Knafl (2005) regarding literature search and presentation of the findings were also incorporated to enhance the rigour of the review.

According to Creswell (2003), the first step in conducting a literature review is to identify key words for undertaking the next step, the literature search. I identified health promotion, empowerment, health equity, health inequity, and health disparities as keywords for this literature search. Creswell (2003) suggests searching the literature on a computerized database and library catalogue. In order to enhance the credibility of this process, Whittemore and Knafl (2005) recommended additional searching methods, such as ancestry search, and networking. To satisfy both recommendations, I used the following methods to identify the relevant literature:

- A search on the Scopus database was undertaken by using the keywords in different combinations. There was no time limit for the publications. English, Spanish, and Portuguese language publications were included. Both theoretical and empirical studies were selected;
- A search on the University of Western Ontario (UWO) library catalogue was also conducted using the same keywords. The focus of this search was to locate more recent literature (e.g., 1999 to present) written in English;
- Additional articles, books, and reports were selected by networking and cross referencing the bibliographic lists of the initial literature.

The number of potential publications to be included in this review was rather large; however, because it would be overwhelming to work with such a larger number of publications, I considered the following criteria inspired by Creswell (2003) to limit the material to be included in this review:

- historical importance of the publication;
- importance of the author(s) for the field(s) of study;
- literature that integrates the three main topics in a single work;
- articles and books that present a disputed or controversial view of the topics;
- current literature on the topics.

Following these criteria, I first selected the classic literature in the field (e.g., the Declaration of Alma-Ata, and articles from authors such as Rappaport and Labonte). Next, I chose some articles and books from widely recognized experts in the health promotion and health equity fields (e.g., Laverack, 2004, 2009; Marmot, 2005; Minkler, 1989; Tones, 1998a; Wallerstein, 1993). I then selected the most relevant publications by cross referencing the bibliographic list of the articles and books and networking with

my advisory committee and colleagues. A total of 87 publications comprised of articles, reports, and books were included in this literature review.

In Step 3 of the literature review process as described by Creswell (2003), I designed a literature map (Figure 1). The two main purposes of this illustrative map are: (a) to present some publications which are central to understanding the topic of health promotion, health equity, and empowerment; and (b) to locate this review within the large set of research in these topics. As shown in Figure 1, this literature review is located in the intersection of the three topics of this study because it integrates the three main topics of this research.

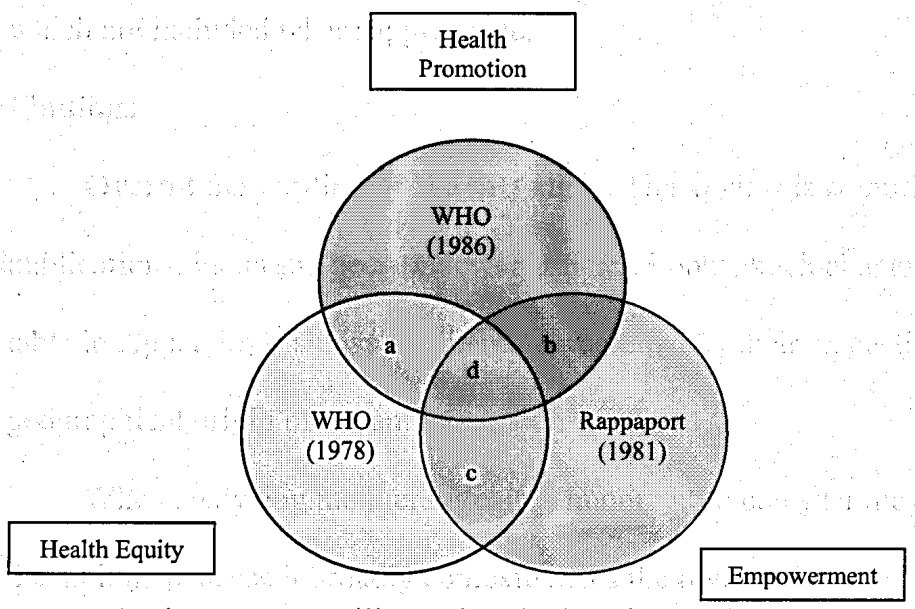

Figure 1. Literature map illustrating the location of the proposed study within the large literature (d). Works cited in this figure represent seminal literature of each area. Legend (a) Wallerstein & Freudenberg (1998); (b) Labonte (1993); (c) Israel, Checkoway, Schulz, & Zimmerman (1994).

The fifth step of this review is the analysis of the selected literature. The analysis was made thematically (Creswell, 2003). First, I reviewed the selected literature and, in light of the objectives of the study, I identified three themes: (a) the centrality of health equity to health promotion; (b) the utilization of empowerment strategies within health promotion interventions; and (c) organizational empowerment strategies as a mean to address health inequities. Then, I carefully read the literature and summarized the data

into a chart to facilitate visualization of the themes and characteristics of the material, as recommended by Whittemore and Knafl (2005) (see a sample of this chart in Appendix A).

The final step in the literature review process as stated by Creswell (2003) is to write the report. In what follows, I present the findings of this review by summarizing the characteristics of the literature reviewed and outlining the main features in the each theme. Whittemore and Knafl (2005) suggest that the findings be presented in tables, diagrams, or figures to facilitate the visualization of the data. Following this recommendation, I designed several figures and tables to illustrate the main findings which are included where appropriate.

Findings

Overall description of the literature. This review is comprised of 87 publications, including peer-reviewed articles, books, book chapters, and reports. The table in Appendix B shows the literature included by their respective themes and geographical origin of the authors.

When analyzing the literature, it is important to consider the country of origin of the authors because it broadly contextualizes the reviewed studies. Regarding the geographical origin of the author(s) of the selected literature, the majority of the authors are from the USA (n=38) followed by Canada (n=12) and Brazil (n=6) (see Figure 2). There are also publications from UK (n=5), New Zealand (n=2), Australia (n=1), Hong Kong (n=1), Israel (n=1), Norway (n=1), and Taiwan (n=1). Nineteen works were developed by international research dyads or teams. Authors of these dyads or teams are from countries around the world including Canada, the USA, Sweden, Finland, the UK, Belgium, Chile, Cuba, Japan, Sudan, and Zimbabwe. Conference declarations were also included in the international group.

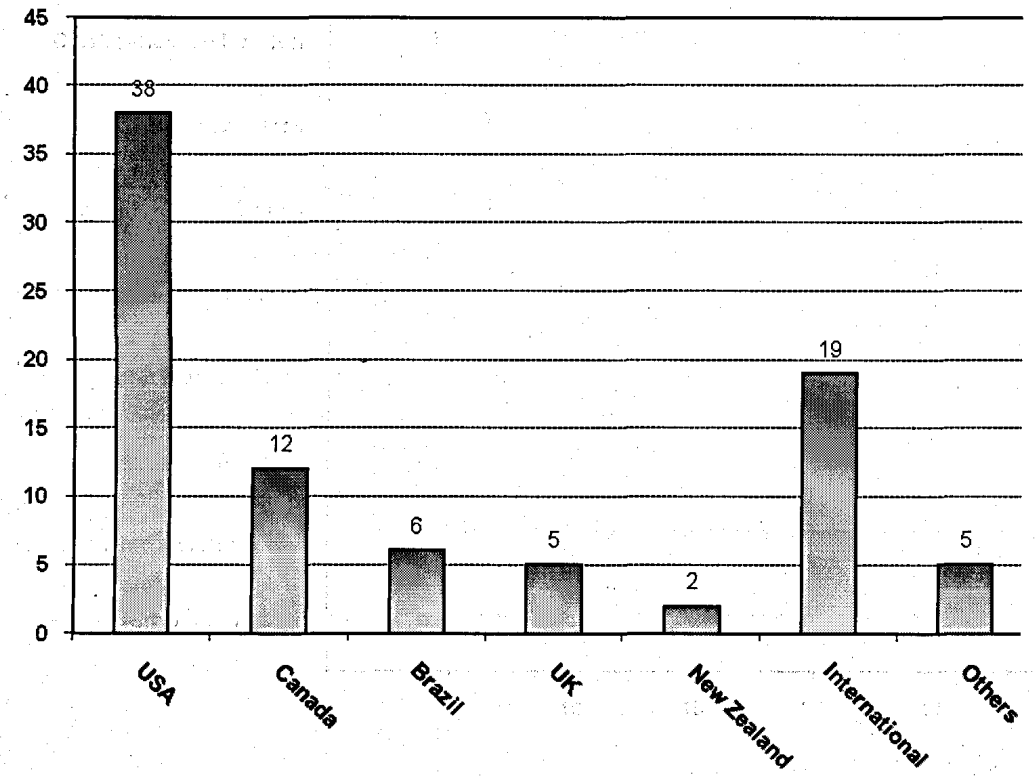

Figure 2. Origin of the author(s) by country (n=87). *International* means a dyad or group of authors from more than one country and conference declarations. *Others* include one single study from the following countries: Australia, Hong Kong, Israel, Norway, and Taiwan.

The methodological designs of the selected literature are also central for analyzing from which perspective the knowledge was produced. In this review, 32 articles are peer-reviewed qualitative case studies, 29 peer-reviewed discussion papers, 8 organizational or government reports, 5 peer-reviewed literature reviews, 5 peer-reviewed quantitative case studies, 4 whole books, 3 books chapters, and 1 conference declaration (see Figure 3). The publications bring a variety of methodological approaches, but the large majority of them (n=82) can be considered qualitative research approaches and experts' opinion pieces.

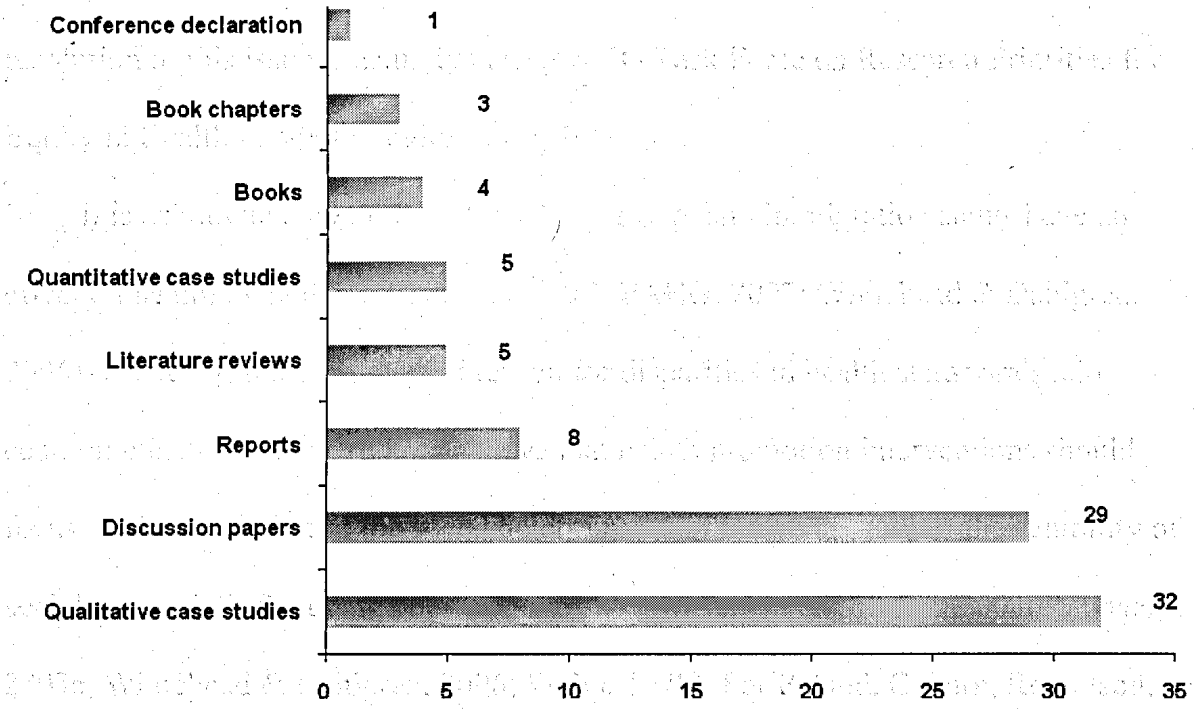

Figure 3. Research design adopted by the selected literature (n=87).

Regarding the language of the selected works, English language literature is utilized in the majority of the publications (n=80). Only five articles were written in Portuguese and one in Spanish.

Theme 1 – The centrality of health equity to health promotion. There is an agreement among scholars that social, and economic disparities are detrimental to the health of the world population (Israel, Schulz, Parker, & Becker, 1998; PAHO, 2007; PHAC, 2003; 'The Copenhagen declaration on reducing social inequalities in health', 2002; Tones & Tilford, 2001; Wallerstein, 2002; WHO, 1978). For this reason, many health experts and institutions are calling for effective interventions that advance social, political, economic, and environmental conditions to improve people's health (IUHPE & CCHPR, 2007; K. D. Travers, 1997; Wallerstein & Freudenberg, 1998; WHO, 2005).

Some scholars have insisted that health equity should be in the agenda of governments, local and global research, as well as health practitioners (Braveman & Tarimo, 2002; Marmot, 2005). A WHO research team reported that, despite the growing

awareness of the need to address health inequities, little political action toward the resolution of this issue is actually taken (WHO Task Force on Research Priorities for Equity in Health & WHO Equity Team, 2005).

It is acknowledged that gender, ethnic group, and immigration status have an effect on health (Mundel & Chapman, 2010; PAHO, 2007; Whitehead & Dahlgren, 2006). However, the most studied reason for disparities in health status are socio-economic factors. Many authors believe that health promotion interventions should focus on the resolution of the social determinants of health because of the centrality of social factors in influencing population health (Braveman & Gruskin, 2003; Raphael, 2003c; Whitehead & Dahlgren, 2006; WHO, 1978). For Poland, Coburn, Robertson, and Eakin (1998), addressing the social determinants of health does not mean that decision-makers should focus their attention only on economic prosperity. These authors have claimed that addressing the social determinants of health should not be simplified by investing in economic growth and reducing the health costs while waiting for health improvement; rather, governments should invest in social sectors (such as education, housing, and employment) that improve population health (Poland et al., 1998).

Theme 2 – Empowerment strategies within health promotion interventions. Östlin et al. (2009) acknowledge that political, economic, and social changes are required to accomplish both empowerment and health improvement. As de Vos et al. (2009) point out, "Without due analysis of power relations and interests, it is impossible to work with empowerment" (p. 31). Power imbalances within and between population groups also negatively influence people's health (de Vos et al., 2009; Israel et al., 1994; Wallerstein, 1993). McKnight (1985) agreed when he wrote, "...it is impossible to produce health among the powerless" (p. 38). Because of this link between health and

power, empowerment strategies have been in the forefront of health promotion strategies as a way to promote health and equity (Bernstein et al., 1994; de Vos et al., 2009; Ratna & Rifkin, 2007; Wallerstein, 2002).

Riger (1993) and Weissberg (1999) provide an overview of the most used terms to describe empowerment, but most of these definitions use the expressions *control over* or *mastery over* to define empowerment. Indeed, the great majority of the definitions found in this literature review contain those terms (see for example, Bernstein et al., 1994; Hawe & Shiell, 2000; Israel et al., 1994; Laverack, 2004; Lugo, 1996; Peterson & Zimmerman, 2004; Rappaport, 1981; Sapag & Kawachi, 2007; Stang & Mittelmark, 2009; Wallerstein, 1993; L. Williams & Labonte, 2007; Zimmerman, 2000). The focus of control could be from individuals' body to the environmental, political, and social resources (Pereira, 2003; Bernstein et al., 1994).

Several scholars have suggested that interventions which adopt empowerment strategies are successful in promoting health (Barten, Mitlin, Mulholland, Hardoy, & Stern, 2007; Caragata, 2000; Guldan, 1996; Laverack, 2006; Rifkin, 2009; Simons-Morton & Crump, 1996; Wallerstein, 2002). Many also have highlighted that empowerment strategies enable individuals, communities, and organizations to address social and political issues that affect their health (Becker et al., 2007; P. Carey, 2000; Labonte, 1992; Laverack, 2006; Merideth, 1994; Maton, 2008; K. D. Travers, 1997; Wallerstein & Bernstein, 1994; Yoo et al., 2004).

Several examples of health interventions adopting empowerment strategies at the individual and community levels could be found in the literature. These interventions adopt a variety of methods to apply empowerment strategies, such as group and one-to-one dialogues (Geounuppakul, Butraporn, Kunstadter, Leemingsawat, & Pacheun, 2007; Stang & Mittelmark, 2009; Wallerstein, & Martinez, 1994), developing

awareness raising campaigns (Lopez et al., 2007; Wilson, Minkler, Dasho, Wallerstein, & Martin, 2008), and building partnerships and networks in neighborhoods (Wells, Miranda, Bruce, Alegria, & Wallerstein, 2004), schools (Wallerstein, & Freudenberg, 1998; A. B. Williams et al., 2005), and churches (Maton, 2008).

Many authors also have challenged the current empowerment strategies. They have claimed that the adoption of this concept varies from intervention to intervention, depending on the political perspective of the government or group who retains the power to finance, develop, implement, or evaluate the programs (Carvalho 2004; Carvalho & Gastaldo, 2008; Ferreira & Castiel, 2009; Rissel, 1994). Riger (1993), for instance, suggested that empowerment strategies may be detrimental depending on the target population when she wrote, "there is a danger... that community empowerment can be substituted as a goal when what people actually need is better jobs and more income" (p. 289). For Carvalho (2004), government or other agencies may justify reductions in health costs if empowerment strategies are analyzed from an individualistic perspective, in which people should regulate their own life without the interference of the state. Further, Rappaport (1981) asserted that, although the empowerment concept suggests collaboration and democracy, the current capitalist mindset values individualistic approaches to health interventions.

Another point of researchers' criticism is that empowerment could be viewed as a feeling or sensation (a way to make people feel better), rather than as a concrete change in the reality, for example, an actual change in the distribution of power, and resources (Carvalho, 2004; Carvalho & Gastaldo, 2008; Ferreira & Castiel, 2009; Riger, 1993; Weissberg, 1999). In addition, Reybold and Polacek (2006) and Braunack-Mayer and Louise (2008) caution that having a theory of empowerment is not sufficient to work toward the empowerment of populations. For these authors as for Bernstein et al (1994),

other practical variables such as gender, education level, and time influence the development of empowerment-based interventions. Going further, Reybold and Polacek (2006) stressed that health organizations should give attention not only to the community they work, but also the "community" they are.

Continuing with the criticisms, Braunack-Mayer and Louise (2008) posed some ethical dilemmas in undertaking community empowerment programs. For those authors, since the empowerment strategies imply a certain autonomy level of the target community or population, "If the community's choices prior to the empowerment process are not fully autonomous – if the community is not capable of identifying its values or interests properly – then this might create a licence for paternalistic intervention" (Braunack-Mayer & Louise, 2008, p. 6). Also,

> the health promotion practitioner who gives communities control over the identification of problems, and the design and management of health promotion programmes, can find herself in the position of supporting, advocating, and delivering funding for programmes that she considers ill-advised. (Braunack-Mayer and Louise, 2008, p. 6)

Finally, Weissberg (1999) also cautioned that empowerment strategies may not be *the best* approach to improve people's health, since the health interventions should vary according to the needs of the population.

Theme 3 – Organizational empowerment within health promotion. For Rifkin (2009), organizations play a central role in addressing health inequities through empowerment. Braveman and Tarimo (2002) argued that health organizations should move health promotion toward the utilization of the social-ecological practices. These authors acknowledge that health organizations alone are not able to resolve the health inequity problems; but, organizations can create political ground for the resolution of

these issues. Peterson and Zimmerman (2004) suggest that organizational empowerment (OE) is a relevant concept to be applied to create such ground. For Hughey, Peterson, Lowe, and Oprescu, (2008), "OE refers to organizational efforts that generate PE [psychological empowerment] among organization participants as well as organizational effectiveness needed for goal achievement" (p. 652). However, as Peterson and Zimmerman (2004) suggested, this definition considers only individual level constructs of empowerment; for those authors, research dealing with characteristics that include organizational features of empowerment process is needed.

Interestingly, some researchers affirmed that there is an important distinction between *empowering* and *empowered* organization (Peterson & Zimmerman, 2004; Swift & Levin, 1987; Zimmerman, 2000). An e*mpowering* organization should be concerned with processes that foster PE among professionals working within an organization (Zimmerman, 2000). An *empowered* organization, on the other hand, defines the influence of organizations on the larger social system in which they are part (Peterson & Zimmerman, 2004; Swift & Levin, 1987; Zimmerman, 2000). Acknowledging this difference is central to empowerment practices because the idea of *empowered* organizations advance the empowerment theory when it goes beyond the individual level of analysis and incorporates an ecological perspective of health.

Many studies have explored the idea of *empowering* organizations (Appelbaum, Zinati, MacDonald, & Amiri, 2010; Gutierrez, GlenMaye, & DeLois, 1995; Hughey et al., 2008; Itzhaky & York, 2002; Kuokkanen, Suominen, Härkönen, Kukkurainen, & Doran, 2009; Laschinger, Sabiston, & Kutszcher, 1997; Maton & Salem, 1995). On the other hand, few studies have explored the concept of empowered organizations in health promotion interventions (Griffith et al., 2010; Israel et al., 1994; Merideth, 1994; Minkler, Thompson, Bell & Rose, 2001; Rifkin, 2003).

It has been suggested that in order to reduce social disparities and to promote health, health organizations must not only work toward *empowering* health professionals and communities, but must act as *empowered* organizations (Barten et al., 2007; Kjellstrom et al., 2007; Maton, 2008; Minkler et al., 2001; Pilisuk et al., 2005; Wallerstein, 2006). For Peterson and Zimmerman (2004), OE is a useful concept that organizations should apply to strive for social changes necessary to improve people's health. Indeed, they developed a nomological framework for helping the research and practice on *empowered* and *empowering* organizations. This OE framework describes three components of OE: intraorganizational, interorganizational, and extraorganizational. That is,

> The intraorganizational component of OE includes characteristics that represent the internal structure and functioning of organizations. The intraorganizational component is critical because it provides the infrastructure for members to engage in proactive behaviors necessary for goal achievement. The interorganizational component of OE includes the linkages between organizations. The interorganizational component is vital because it refers to the relationships and collaboration across organizations. The extraorganizational component of OE refers to actions taken by organizations to affect the larger environments of which they are a part. The extraorganizational component is crucial because it represents organizational or multiorganizational efforts to exert control. (Peterson & Zimmerman, 2004, p. 131)

The intraorganizational component entails six processes: (a) incentive manager; (b) subgroup linkage; (c) opportunity role structure; (d) leadership; (e) social support; and (f) group-based belief system. The interorganizational component is comprised by two processes: (a) accessing networks of other organizations, and (b) participating in

alliance-building activities with other organizations. Lastly, the extraorganizational component includes implementing community actions, and disseminating information (Peterson & Zimmerman, 2004). For the authors, these processes are part of OE interventions within and outside organizations and ultimately help organizations to identify central strategies to become an *empowered* organization.

Discussion

General characteristics of the literature. The findings of this review suggest that the literature about empowerment, health equity, and OE is concentrated in developed countries (i.e., US, Canada) – although the target population of the empowerment interventions within these countries are ethnic minorities or vulnerable groups (i.e., African-Americans, Latino immigrants, people experiencing homelessness, and low-income groups). This fact poses a challenge to the incorporation of the studies into other contexts because the developed countries have their own historical, economic, social, and cultural factors that shape the development of health promotion interventions. For this reason, more research is necessary to explore empowerment strategies within diverse contexts. As Poland (2007) said,

> We can expect the centre of gravity of health promotion to shift significantly from the countries of the North (who have had the luxury resources and privileged access to international scholarly journals and have thus appeared to have 'led' the development of health promotion) to countries of the global South where the most pressing problems (and creative solutions) will be seen. Increasingly, the voice of the South must be heard in mainstream and international health journals, conferences, and forums (this process has begun, but many barriers remain). Too much wisdom and experience is not being made available to the rest of the world. (p. 9)

Regarding the epistemological approaches that have been adopted in this field, I have grounds to conclude that a large body of literature about empowerment and health equity is dominated by qualitative research methodology even though I acknowledge that the literature in this review was purposefully selected. This fact has implications due to the way the academic world perceives the value of the knowledge produced by qualitative research methodology. Qualitative research methods are generally considered in the lower hierarchies of evidence because the research techniques can not be controlled and precisely reproduced and so it creates a *biased* research approach (Whiteford, 2005). A different view is proposed by Devisch and Murray (2009) when they endorsed that "strict distinction between admissible evidence (based on RCTs [randomized control trials]) and other supposedly inadmissible evidence is not itself based on evidence, but rather, on intuition" (p. 950). The debate over the importance of qualitative and quantitative research methodologies is complex and disputable (Raphael, 2000), but Tannahill (2008) tried to synthesize his opinion as follows:

> there is no 'one-size fits all' method for health improvement effectiveness evidence; RCTs have their place but also their limitations; other study designs are the best available for some actions (notably including many policies); and complex, multifaceted evaluations (which may include RCT components) are needed for complex, multifaceted interventions. (p. 382)

Schulman (2010) states, "Applying evidence or synthesizing best practice or even conducting a community needs assessment is not the same as generating new ideas" (p. 3). Because qualitative inquiry allows the researchers generate new ideas by examining in depth the constructs and contexts of health promotion interventions, I believe that qualitative research methods are also relevant for the production of knowledge in this field.

Notwithstanding this debate, the fact is that expert opinions and case studies, for example, are still considered in the lower level of the research inquiry hierarchy (Whiteford, 2005). This fact can downplay the utilization of qualitative studies by health professionals that seek evidence-based knowledge; as a result, health professionals may not embrace community empowerment because the evidence of its utilization may not be considered strong enough to be widely used.

Discussion of the themes. There seems to be a consensus among scholars that health equity is relevant for the health promotion field. In addition, broader social, political, environmental, and economic factors influence the health of the population and are essential to the reduction of health inequities. Health promotion research that utilizes a socio-ecological perspective is consistent with the current call for interventions targeting the resolution of health inequities. It is clear that health organizations play an important role in advocating for a favorable social, political, and economic environment that promotes health and reduce health disparities.

The literature reviewed here suggests that empowerment strategies can provide a theoretical and practical basis to develop and implement health promotion programs that target health inequity. Despite the fact that empowerment theories have received many criticisms and that a clear definition is still controversial, empowerment strategies are still relevant for health promotion. There remain some gaps with respect to the definition of empowerment in the literature and so I turn to Paulo Freire (Shor & Freire, 1987). Freire's empowerment conceptualization entails a process of learners becoming active subjects in their learning process and their lives: "If learning to read and write is to constitute an act of knowing, the learners must assume from the beginning the role of creative subjects" (Freire, 1998b, p. 485). In addition, for Freire (Shor & Freire, 1987), empowerment encompasses a *collective process* of consciousness raising in which

people increase their political, economic, and social power by applying their knowledge, in connection with their peers, and reflecting upon their actions. As a result, the term *control over* (which in my opinion implies a fixed condition) does not encompass all the dynamic and collective processes of empowerment as advocated by Freire. Also, I agree with some authors presented in this review when they say that an *idea* of empowerment is different from a *practice* of empowerment, and the first one does not lead to the other (Carvalho, 2004; Carvalho & Gastaldo, 2008; Riger, 1993; Weissberg, 1999).

A fair amount of literature could be found on the three levels of empowerment (psychological, organizational, and community); however, studies adopting organizational empowerment approaches are few in comparison to the other levels. More importantly, it seems that the majority of research on OE explores the concept of *empowering* organizations and does not address the characteristics of *empowered* organizations, which includes an ecological perspective of health. More research about the development of *empowered* organizations is needed in order to facilitate the adoption of empowerment concepts in health promotion practices. The OE framework developed by Peterson and Zimmerman (2004) is relevant to examine empowerment strategies at the organizational level, even though the concept of empowerment adopted by this framework relies on the term *control over* and it does not consider all the dimensions of power relations, such as the relations between government and organizations, as well as communities and organizations.

As limitations of this literature review, it is important to consider that the selection of the literature was based on criteria that can be subjective, which might undermine the trustworthiness of the review; however, by following the methods and criteria as outlined by Creswell (2003), I intended to minimize this shortcoming. Moreover, I selected a fairly large number of publications in an attempt to represent the body of the

literature on the topics of study. Other drawback of my literature review is that, although I recognize that there are many publications on OE strategies in the organizational and management studies, I was unable to review the literature in these fields, instead I chose to focus on the health promotion field.

Conclusion. The concept of OE can be useful to enable empowerment both within and outside the organizational structures. More importantly, OE can enable organizations to become *empowered* and adopt a more ecological view of health promotion. However, to foster OE, a clearer understanding of empowerment among health professionals within an organization is needed (Peterson & Zimmerman, 2004; Laverack, 2004). Accordingly, this study aims to explore the understandings and practices of empowerment of professionals in a single health promotion organization.

The next chapter describes the conceptual framework that inspired this thesis and details how this study was carried out.

Chapter 3: Study Design and Methods

In this chapter, I introduce the methodology and methods used to conduct this study. In the first part, I outline both the study design and the conceptual framework and provide the rationale for these items. In the second part of this chapter, I specify the methods of selecting the studied organization, the recruitment of the participants, and the processes of data collection and analysis. Finally, I explain my approach to reflexivity, ethical considerations, and quality criteria.

Study Design

A case study design was chosen to this study because, as Stake (2005) argues, "case study is not a methodological choice but a choice of what is to be studied" (p. 443). Stake adds that case studies' strengths and weaknesses lie on the emphasis on the unique processes that can be learned from a single case. Following the same lines, Caronna (2010) claims that case studies improve our understanding of health organizations by exploring their unique context and processes. Gerring (2007) defined case study "as the intensive study of a single case where the purpose of that study is – at least in part – to shed light on a larger class of cases" (p. 20). The general characteristics of case studies can be synthesized as follows:

1. Case studies are focused on a single case, such as one person, a family, a company (Willis, 2007);
2. Data collection methods in case studies are naturalistic (i.e., they explore real people in real context) (Gerring, 2007);
3. Case studies provide a detailed and comprehensive description of the case (Gerring, 2007; Patton, 2002);

4. Case studies are inductive. This means that "Generalizations, concepts, or hypotheses emerge from the examination of data" (Merriam, 1988, as cited in Gerring, 2007, p. 13).
5. Case studies serve to understand or examine a phenomenon of interest (Gerring, 2007; Willis, 2007).

The case study approach fits the objectives of this research, which is to examine the understanding and practices of a health promotion organization, because it considers the organization's unique contexts and processes. This study is an *instrumental case study*; that is, "the case study is of secondary interest, it plays a supportive role, and it facilitates our understanding of something else" (Stake, 2005, p. 445). Instrumental case studies look at a single case in depth as well as scrutinize its context and activities in order to advance our understanding of other constructs of interest. As such, in this study I hope to shed light on topic such as organizational empowerment processes in the health promotion field.

Conceptual Framework

The concepts of empowerment are central for this study. The work of the Brazilian educator Paulo Freire has been credited with developing the notion of empowerment within the health promotion field (Goodson, 2010; Robertson & Minkler, 1994; Simons-Morton & Crump, 1996). McLaren (2000) argues that the roots of Freire's ideas are grounded in many different paradigms, but that his theories entail a critical theory stance. Tones (1998a) suggests that the foundation of empowerment approaches within the current health promotion movement is grounded on critical paradigms. As a result, the conceptual framework of this case study is consistent with the critical theory paradigm.

Critical theory is not easy to define. Guba and Lincoln (1994) included many theories such as the one informed by feminism, neo-Marxism, and participatory inquiry within the scope of critical theory. Kincheloe and McLaren (2005) state, "critical theory attempts to avoid too much specificity, as there is room for disagreement among critical theorists" (p. 303). However, in general, critical theory is concerned with the issues of power that influence all the aspects of human life (Willis, 2007). Economic, cultural, race, and gender values represent forms of oppression that critical theorists put special effort on critiquing (Carpenter & Suto, 2008). As Chouliaraki and Fairclough (1999) argued, "every moment in the structure/action dialectic is a moment in the power struggle over whether the social world is to be maintained as it is or changed" (p. 32). Thus, the purpose of research for critical theorists is to uncover power imbalances within the social relations.

Because critical theorists are concerned with issues of power, the notion of hegemony is essential to explain how dominant classes exercise control over the population (Carpenter & Suto, 2008; Kincheloe & McLaren, 2005). The structure of power and hegemony in the society influences the thoughts and actions of people by making the oppressing system seems natural and maintains the oppressed class in the lower position of acquiring, for example, knowledge, employment, education, and housing (Kincheloe & McLaren, 2005). Further, the ontological assumption of critical theory involves that there is no objective social reality; because human beings influence and are influenced by social, political, economic, cultural, ethic, and gender values, it is pointless to unify the complexity of the world into a single reality (Guba & Lincoln, 1994). Consequently, as Morrow and Brown (1994) put it, "'social facts' are qualitatively different from 'facts' of nature because they are created and re-created by our own actions as humans being... Humans beings have a unique capacity to change

their behavior in response to knowledge about it" (p. 9). While human beings are determined by social values, they have potential to change their environment when they acknowledge a need for a change (Shor & Freire, 1987).

Language is an important feature of critical theory as it "is central to the formation of subjectivity (Kincheloe & McLaren, 2005, p. 304) and it may represent the hegemonic social norms and values (Wodak, 2001). Fairclough (1999) argues that key aspects of social life have been increasingly centered on language and other semiotics. Additionally, language has internalized other aspects of social life, such as economic and political lives (Fairclough, 1999) and, as such, the language of research and the research processes have internalized features of the general system (Lather, 1991). For critical theorists, the research process is not neutral. Rather, researchers have to be explicit about the standpoint they are adopting for making sure readers are informed about their point of view. In the next section of this chapter, I outline the specific methods I used to conduct this study.

Sampling Strategy

This study utilized a sampling strategy consistent with *intensity sampling* (Patton, 2002; Stake, 2005). Intensity sampling is a strategy for selecting a case that "we feel we can learn the most" (Stake, 2005, p. 451). To that end, broad inclusion criteria were framed to assist in the identification of a relevant organization for this study:

- The organization should work within health promotion and health equity mandates;
- The participants need to have some acquaintance with the empowerment concept;
- The organization should be located in Ontario.

To find an organization that satisfied these criteria, I performed a search on Google, using the following search keywords: Ontario, health promotion organization, and equity. From this search, I found a website of a health promotion organizations' consortium, which lists the information and contact details of many Ontario organizations. From this list, I visited the websites of many health promotion organizations to learn about them and this process led me to an organization that satisfied my inclusion criteria. What called my attention in the selected organization was the fact that, in its mission statement the organization explicitly states its mandate to reduce health inequities. Because of this, I felt that with this organization I could have much to learn about the interrelations between health promotion, organizational empowerment, and health equity. It is important to note that I am aware that many more organizations could have been identified, but this organization satisfied the criteria, so I decided to contact this organization first before continuing the search. I contacted this organization by email and I quickly received a positive response. I scheduled a telephone conference and a personal meeting with staff members so that I could provide more details about the research project. Fortunately, after my discussions with some staff members, this organization agreed to participate in the study and no other organization was contacted.

Data Collection Methods

To gather the relevant information about the organization's understanding and practice of empowerment, my supervisor and I conducted two focus groups at the organization's facility, one with members of staff, and a second with members of the board of directors. Nine organization's annual reports (from 2001 to 2010) were also included as data for this research. Due to time and financial constraints, I could not include some data collection methods that would raise more information about the

organization's understanding and practice of empowerment, such as in-site observation and comprehensive document analysis. However, I consider that the data set collected was enough to have a good understanding of the organization conceptualization and practices of empowerment. In the next sections, I provide the specific details on the data collection process.

Focus group. In this section, I describe the theoretical approach adopted to conduct the focus group interviews, the participants' recruitment process, and the practical details of the focus groups.

Theoretical foundations. Since the objective of this study was to bring participants' voices into the research process, focus group interviews were used to learn about the organization's understanding of empowerment. The focus groups were informed by Freire's conceptualizations of dialogue (Freire, 1993; Shor & Freire, 1986).

For Freire (1993), dialogue is a social process that has the power to de-construct and re-construct the reality and it enables individuals to think critically about their lived reality for the ultimate purpose of transforming this reality (Shor & Freire, 1986). It is true that Freire developed his ideas of dialogue for the education field; however, these ideas can be adopted in research practices as some scholars have already done (Kamberelis & Dimitriadis, 2005; Labonte, Feather, & Hills, 1999; Tandon, 1981).

Adopting a dialogical approach informed by Freire, my supervisor and I[1] aimed not to control the outcomes of the dialogue, but to include the participants in a position of co-creators of the collective understanding of empowerment. Thus, during the focus group dialogue, we were not moderators or facilitators of the dialogue. In contrast, we tried to act as participants and were included in the production of "polyvocal texts"

[1] Morgan (1995) suggests that focus groups should be conducted by at least two moderators, depending on the experience of the researchers

(Kamberelis & Dimitriadis, 2005, p. 888). This standpoint yielded a more open environment, with no structured script.

Although research practices that adopt dialogical processes tend to be emancipatory and transformative (Tandon, 1981), the practice of dialogue has challenges and dilemmas. Since the theory of dialogue may be different from the practice (Ellsworth, 1989), the outcome of a dialogue is always unpredictable. Also, just like other data collection methods (such as interviews), the researcher and the participants may use their positions of authority to manipulate the dialogue (Burbules, 2006; Pruitt & Thomas, 2007). As a result, some voices may be, purposively or not, silenced (Ellsworth, 1989). Acknowledging the possible influence of positions of authority over the participants of the focus groups, two focus group meetings were conducted with different compositions: the first one was comprised by staff members (from administrative to management positions) and the second one by members of the board of directors.

It is important to note that a dialogue about empowerment not necessarily will reflect empowerment practices. The dialogical process in the group meeting may not represent the practical experiences of the participants and, as a consequence, may hide uncooperative or authoritarian practices. To address this issue, the participants in this study were encouraged to provide concrete examples of their realities to illustrate their comments, a strategy advocated by Shor and Freire (1986).

Details on the dynamic occurred during the focus group will be provided in the data anlysis section. Now I turn to the recruitment of the participants of the focus groups.

Practical elements of the focus group and participants' recruitment. Before the beginning of the recruitment process, clearance was obtained from the Health Sciences

Ethics Board at the University of Western Ontario (UWO) (see Appendix C). This approval pertained the recruitment of participants with an assistance of organization's gatekeepers. The organization indicated two staff members to assist in the recruitment: one staff member with no managerial role was responsible for the recruitment of the staff; a second staff member with a managerial role recruited members of the Board of the Directors. Both gatekeepers invited potential participants by sending an email with the Letter of Information (see Appendix D) provided by the researchers and approved by the UWO Research Ethics Board. It is important to highlight that the researchers did not contact any potential participants directly, but information about how to contact the researchers was sent with the invitation to participate in the study. The participants who agreed to participate in the focus group responded to the gatekeepers; then, the gatekeepers forwarded their responses to me. At this point, I grouped together the recruited participants and organized the details (date and time) for the focus group meetings by email directly to each one.

Finally, my supervisor and I conducted two focus groups in the organization's facility after the participants signed the informed consent (Appendix E). The first focus group was comprised of eight staff members. Three members of the board of directors participated in the second focus group. Both meetings were audio-recorded and I transcribed verbatim all the material. Cognoscente that English is my second language and that it could create some communication difficulties, all the transcripts were reviewed by an English native speaker to ensure the accuracy of the material. Again, ethical clearance was sought to this review process.

After the first round of focus groups was complete, I prepared a summary of the analysis (Appendix F) and sent it to all participants. Engaging in a conversation about the first draft of the analysis would provide another opportunity for the participants to

ratify, rectify, or clarify initial findings of the analysis and enhance the rigour of the study. However, only one board member responded, but suggested no changes to the summary.

Document Analysis

In the modern world, written documents are important ways of social communication (Peräkylä, 2005) and organizations, clinicians, and governments, for example, rely on written documents to set up policies, behaviors, and routines (Prior, 2004). Documents may enable or constrain human actions and interactions within an organization and researchers who include document analysis in their study need to focus on "*people's local and collaborative in situ work and interaction with and on documents*" (Rapley, 2007, p. 87, italics in original).

Documents are situated materials because there are (or there were) reasons for people to produce them and they are agents of human interaction because people spend time and resources to write, read, apply, or ignore documents (Prior, 2004). Documents are "already existing data" since the material was produced independently of the work of the researcher (Rapley, 2007, p. 9). However, researchers are not passive in the process of collecting documents; rather, they have an active role in discovering and determining which documents will be included in the dataset (Rapley, 2007).

Several types of documents (e.g., reports, newspapers, letters) can be used in research (Rapley, 2007). The selected organization in this study produces an overwhelming number of potential documents which could be analyzed. I chose to focus on nine of the organization's annual reports (from the years 2001 to 2010) because they provide a good account of the organization's practices, mission, vision and goals and also cover a long period of time. Additional documents (e.g., the

organization's website, published articles about the organization), were also used to gather additional information (e.g., the historical context) about the organization.

It is acknowledged that documents "are not transparent representations of organizations routines, decision-making processes, or professional diagnoses" (Atkinson & Coffey, 1997, as cited in Silverman, 2003). For this reason, the researcher needs to explore the context in which the document was developed; the document functions in the context it is supposed to be produced and consumed; and the way it circulates among the target audiences (Prior, 2004). This study did not gather information on all of these details and this can be perceived as a limitation of the study. More details of this shortcoming will be provided in the limitations of the study section.

In sum, two focus groups interviews and nine organization's annual reports were used to examine the organization's understandings and practices of empowerment. Together, these data collection methods enriched the study with relevant information that provides a broader picture of the case. Since this study sought to create a collaborative climate with the studied organization, in the following section, I address some collaboration issues that were raised during the conduction of the study.

Issues of Collaboration in Organizational Research Practices

One salient aspect of this study is the fact that it proposed collaborative work with the participating members of the organization. This collaborative approach led to challenges with respect to how this collaboration could be framed and put in practice. Collaborative research is not a new approach in the health field (John-Steiner, Weber, & Minnis, 1998). In the past decade, researchers have been documenting the various benefits and challenges of doing collaborative research. Salmon (2007) argues that collaborative research is an important way to democratize the research process. Charlier, Glover, and Robertson (2009) say that it enhances articulation between the

research mission and objectives. Israel et al. (1998) and Tyler and Horner (2008) suggest that collaboration between researchers and participants increases the power and control of the people involved in the research process. For Johnston and Woody (2008), collaborative research improves culturally sensitive research practices. These authors describe different challenges of collaborative research: time constraint, cultural differences, diversity of expectations, power imbalances, and ethical issues.

In this study, I adopted a collaborative approach to research that was developed by Clark et al. (1996). They state that researchers cannot assume that all the participants of the project "have the time, energy, or interest to be 'equal owners' of a project and making such demands on them may, in fact, be more of a disempowering experience" (p. 196). The openness to many voices during the research process is of importance rather than the fact that all participants share the same responsibilities in the conduction of a collaborative research. In their dialogical approach to collaborative research,

> If, instead of work, dialogue becomes the central, shared feature of collaborative research, then what is gained is a level of understanding about the constraints of one another's practices and an opportunity that allows [the participants] to bring their varying expertise to an endeavor that is potentially enriching to all involved. (Clark et al., 1996, p. 197)

This is consistent with Freire's opinion that, "Dialogue, as essential to communication, must underlie any cooperation" (Freire, 1993, p. 167).

During the research process, I tried to engage in open dialogue with the gatekeepers and the participants on the steps of the research process. In other words, this study "aspire[d] toward" collaborative practices (Clark et al., 1996, p. 197). What actually happened is that one gatekeeper who was also a participant of the first focus group engaged in a relatively closer dialogue with myself, but others participants were

not able to do so for various reasons. This situation was not ideal because I expected that more participants could be involved in the research. However, it is important to highlight that since the beginning of the research, the gatekeepers made clear that the organization as a whole had little time to give to the research because of their work commitments. Therefore, although I expected more involvement, I was aware of the limitations. In the end, I think that this "lack of collaboration" did not negatively influence the research process; rather, it may have been just a missed opportunity for wider learning and cooperation.

In what follows, I address my personal beliefs and motivations that led me to conduct the research in this way

Representation of the Researcher

Reflexivity is an ongoing process of reflecting and raising awareness of the role that researchers play in the knowledge creation process (Finlay, 2002). For many authors, reflexivity is part of the method to ensure study's rigour (Angen, 2000; D. Davies & Dodd, 2002; Finlay, 2002; Humphreys, 2005). For D. Davies and Dodd (2002), for example, reflexive practices allow "more insightful research findings" (p. 285). The act of reflection is essential for Freire's (1993) conceptualization of praxis and social change. Finlay (2002) also suggests that reflexivity practice is important for acknowledging researcher's bias and represent themselves within the research process. Thus, reflexivity leads the researcher to expose their emotions, thoughts, and motivations as well as examine "what I know" and "how I know it" (Hertz, 1997, p. viii).

Hertz (1997) and D. Davie and Dodd (2002) suggest that researchers should apply reflexivity practices from the beginning of the research process. For this reason, I have written a reflexive journal since the beginning of the research to examine my personal

and professional backgrounds and explore how this background can change the research findings and interpretation. Although I am not comfortable in expressing my emotions, I believe that the practice of reflexivity enriches the research. Ferrari (2010) and Humphreys (2005) expressed the same feelings in their paper about their experience with reflexivity practices.

A relevant reflexivity approach was outlined by Reinharz (1997). She identified three categories of selves: (a) brought, (b) research-based, and (c) situationally created. Because these categories resonate with my own view of reflexivity, I used them to develop my reflection. I will discuss them in turn. My brought self can be summarized in the following way: I am female, Brazilian, physician, middle-class, 29 years old, and a daughter of two physicians. I have always had a comfortable life, and had access to many family, social, and educational supports. Although Brazil is not a model of safe and nurturing educational and social systems, I have an outstanding family that has been supporting me in many areas of my life. In addition, I consider my family to be politically engaged as both my grandfathers actively participated in many political activities before the Brazilian military coup in 1964 (and my maternal grandfather was a provincial deputy). Although neither of my parents have ever held an official political post, they participate actively in the political life of their field of work. For them, politics, power, and ideology mattered. I think that my interest in the critical theory paradigm came from my upbringing.

During my medical studies in Brazil, I was intensely involved in the student activism at local, national, and international levels. The most important aspect of this experience is that it brought me an awareness of the importance of power, politics, and ideology in all aspects of social life. One of the pressing challenges that we (the collective I was part of) had was engaging students in issues that we considered

important (e.g., the academic failure of a student and the municipal, provincial, or federal elections). We were also challenged to educate the next generation of activists who would hopefully continue the activism. Reflecting about this time, now I understand that our problem was strictly related to our understanding of empowerment. I believe that these aspects may explicate why I became interested on the concepts of empowerment.

After my graduation I worked as a family physician in a primary health care unit in two different communities in the countryside of the Northeast region of Brazil, which is a historically impoverished region with pervasive social, educational, and health difficulties. In those professional experiences, I realized the detrimental influence of poor social and economic conditions in the health of those communities. I now have a clearer perspective of why the Brazilian healthcare system does not meet the real needs of this population. Also, I experienced the apathy of the population and the health care workers in trying to challenge and change this situation. Similar to the situation I faced during my undergraduate studies, again the problem had to do with the empowerment and engagement of those communities.

In order to find answers to some of my questions about health care (i.e., How can we improve the care for people in need? How can we change Brazil's current reality?), I decided to pursue graduate studies. Since I wanted to have a different perspective of health (beyond the biomedical approach to health), I applied to graduate studies in health promotion (a field that was not much explored in my undergraduate course) in Canada.

During the first term of my graduate studies, I came across literature that incorporated the work of Paulo Freire into health promotion interventions. In Brazil, Freire is well-known by his contributions to the education field; but until then I was

unaware that people around the world were integrating his ideas into the health promotion programs. In light of the work of Paulo Freire and his ideas on empowerment, I found a theoretical conceptualization that perfectly fits to my past challenges in my academic and working lives.

I consider my own understanding of empowerment a novice one. My current understanding of empowerment, which was inspired by Freire's works, has to do with thinking and acting in the world. That is, to be critically aware (to develop critical consciousness) of the complex web of ideology, values, power, and practices that make our world[2] the way it is. Being in the world means actively and reflexively participating in the de-construction and re-construction of the world.

The second category of Reinharz's (1997) selves is the research-based. M. Travers (2001) pointed out that the first step in doing research which adopts a critical theory paradigm is to be aware that something in the society is wrong (because the world is not in the way we want) and that social action is required to change the situation. This thought really resonates with my past experiences.

When I first studied research methodology during my undergrad studies, I despised research in general. I thought that doing research was boring and hard because much of the medical research and practices are based on hard science and impersonal encounters. That may explain why all my attempts to be involved in research activity during that time failed[3]. However, because I was frustrated with the practice of medicine and public health in Brazil, I thought that I could bring some "theory" to my life by having new perspectives of health practices so, I decided to pursue graduate studies.

[2] By world I mean the physical and relational worlds.
[3] However, one should also consider that the university where I did my undergrad has not a strong tradition in performing medical research and I was involved in many other political and academic activities.

When I began my graduate studies in Canada, some of my presumptions about research were confirmed. In my opinion, much of the research and practice of health promotion are based on medical or traditional approaches to research. I persevered and actively looked for research approaches that diverged from these biomedical and positivistic approaches. Finally, for my joy and "research sanity", I finally found a place where I feel comfortable, which is qualitative research under a critical theory paradigm.

In my current studies on research methodologies, when I came across the participatory-action approach, I though that this was exactly what I was looking for; however, because of lack of time, human, and financial resources, I was not able to conduct this type of research. Moreover, my outsider position within the Canadian culture and health system would make this kind of research approach very challenging. I am also an outsider at many other perspectives: personally, I'm a Brazilian; professionally, I am a physician[4] and a researcher in-training; also, I am not part of the organization I studied. Thus, the researcher positions that I brought to this research resonate with my own resistance to see research as a way to objectively see the world, with my understanding of research as a collaborative activity, and with my outsider position in relation to the country, the organization, and the health promotion profession.

In the third category of Reinharz (1997), I will describe my situationally created self in the next chapter together with the analysis of the focus group interviews because it is in line with one of the steps of the data anlysis (see details above). It is worthwhile to note that this process of openly disclosing my personal beliefs and biases about empowerment and the research process since the beginning of the research has enabled me to challenge my own assumptions and previous experiences of empowerment.

[4] Although I recognize that there are some overlaps between physicians and health promoters, those professions have different approaches to health and different practices.

Data Analysis Strategy

This section will discuss the approaches to data anlysis. Patton (2002) states that the process of qualitative research analysis includes both technical and creative dimensions. The technical portion of the analysis is the way the data is organized to help the creative dimension, which is the interpretation process. In qualitative research methodology the division of those dimensions are blurred but the separation ought to be clear (Patton, 2002; Creswell, 2003).

The technical portion of the data analysis in this study was initiated before the focus group meetings with an outlook of the annual reports. This step was important in order to get a sense of the organization's activities and to engage in a meaningful conversation with the participants of the focus groups. After the focus groups, I read the material once more in chronological order to identify general themes that highlighted important aspects of the annual reports. I designed some diagrams with those themes to provide a visual representation of the data (see some sample of these diagrams in Appendix G).

The technical portion of the analysis of the focus group interviews began when I initiated the transcription of the focus groups. To perform the transcription, I adopted the transcription symbols recommended by Sarangi (2010) (see Appendix H). During the transcription, I got a sense of the whole data and wrote some initial thoughts, as suggested by Creswell (2003) and Patton (2002). From this initial step, I identified some key themes for "conceptualizing data, raising questions, providing provisional answers about the relationships among and within the data, and discover the data" (Coffey & Atkinson, 1996, p. 31). Again, I designed several diagrams that describe the central themes the participants articulated during the focus groups (see samples in Appendix G). Through those diagrams, I could compare and contrast the narratives of the staff's

and board members' focus groups with the themes of the annual reports. For the final report, I did not utilize any of those diagrams, but they helped me during the interpretative step of the analysis.

After these processes, I adopted a critical discourse analysis approach to further analyze and interpret the data. Discourse analysis (DA) is not a set of techniques to analyze textual data (Cheek, 2004). Instead, DA "is a broad theoretical framework concerning the nature of discourse and its role in social life, along with suggestions about how discourse can best be studied" (Potter & Wetherell, 1987 as cited in Cheek, 2004, p. 1145). There are many different conceptualizations of discourse that vary according to the frame the researcher wants to give to the data (Cheek, 2004; Fairclough, 2003a). For the purpose of this study, I adopted two complementary concepts of discourse. The first one was articulated by Cheek (2004): "Discourses are the scaffolds of discursive frameworks, which order reality in a certain way. They both enable and constrain the production of knowledge, in that they allow for certain ways of thinking about reality while excluding others" (p. 1142). The second conceptualization I borrowed from Fairclough (2003a): "'Discourse' is used in a general sense for language (as well as, for instance, visual images) as an element of social life which is dialectically related to other elements [of social life]" (p. 215). These conceptualizations are different because Cheek is emphatic about the broad structures that frame the way the discourses are put in practice, while Fairclough highlights the relational and textual features of discourse by focusing on language. They may be seen as complementary because the first focuses on broader social structure and the second gives attention to social events.

Critical discourse analysis (CDA) is an approach within DA (Peräkylä, 2005). CDA is concerned with how language and social relations reproduce different kinds of power and inequalities (Peräkylä, 2005), as well as how social discourses, such as

dialogues and documents, are shaped by structural and interactional societal dimensions (Chouliaraki & Fairclough, 1999; Silverman, 2003; Thorn, 2000). According to Fairclough (2003a), CDA "is based upon the assumption that language is an irreducible part of social life, dialectically interconnected with other elements of social life, so that social analysis and research always has to take account of language" (p. 2). Since CDA offers a critical in depth scrutiny of narratives and documents (Thorn, 2000) and accepts various sources of discourse such as documents and interviews (Fairclough, 2003a; Silverman, 2003), this analytical lens seemed relevant to this study.

To conduct the analysis, I adopted the Chouliaraki and Fairclough's (1999) CDA framework, which I outline in the following section. Fairclough (2003a) also provided practical guidance in undertaking the framework. The significance of using this framework for this study lies on the fact that it allows the conjoint analysis of both social structures and social events in a way that makes explicit the relations between these two features.

Critical discourse analysis framework. Chouliaraki and Fairclough's (1999) critical discourse framework (CDA) is comprised of five steps:

1. A problem (activity, reflexivity).
2. Obstacles of [the problem] being tackled:
   (a) analysis of the conjuncture;
   (b) analysis of the practice re its discourse moment:
      (i) relevant practice(s)?
      (ii) relation of discourse to other moments?
         - discourse as part of the activity
         - discourse and reflexivity;
   (c) analysis of the discourse:

(i) structural analysis: the order of discourse

(ii) interactional analysis

- interdiscursive analysis
- linguistic and semiotic analysis.

3. Function of problems in practice.

4. Possible ways past the obstacles.

5. Reflection on the analysis. (p. 60)

In general terms, this framework pushes the researchers to ground their analysis on a problematic aspect of social practices[5] (the problem); in light of this problem, analysts can identify the obstacles to resolve the problem (Obstacles of the problem being tackled) within the social context (Analysis of the conjuncture), social practices (Analysis of the practice re its discourse moment), and social events (analysis of the discourse). After taking those steps, analysts can discuss how the problem works in the social world (Function of the problem in the practice) and propose changes (Possible ways to surpass the obstacles). Finally, analysts should reflect on their position within the social field and the practices (Reflection on the analysis). The Appendix I presents a visual representation of the CDA framework outlined above.

Chouliaraki and Fairclough (1999) admit that "the framework is rather a complex one, and for certain purposes analysts might focus on one part of it rather than others, but we believe that the complexity is necessary to 'operationalise' the theoretical position we have set out" (p. 59). As a result, they hold some theoretical assumptions that are important to mention. First, the fact that the analysis is based on a problem implies that indeed the social practices are problematic and, therefore, it needs to change (Chourialaki & Fairclough, 1999). The problem identified by the analyst serves

[5] By social practice the authors mean ways that people apply resources (e.g., money and knowledge) to act together in the world (Chouliaraki & Fairclough, 1999).

as a guide to perform the other steps of the framework and the ways to deal with the problem can be identified at macro, meso, and micro levels. The macro level concerns the analysis of the social structure, which in terms of the framework above is the analysis of the conjuncture. The analysis of the practices in the framework above is the meso-level of analysis. Finally, social events are within the micro level, which comprises in the analysis of discourse. Fairclough (2003a) explained the interrelation of these three levels as follows,

> Social structures are very abstract entities. One can think of a social structure (such as economic structure, a social class, or a language) as defining a potential, a set of possibilities. However, the relationship between what is structurally possible and what actually happens, between structure and events, is a very complex one. Events are not in any simple and direct way the effect of abstract social structures. Then, relationship is mediated – there are intermediate organizational entities between structures and events. Let us call them 'social practices.' (p. 23)

Fairclough (2003a) incentivizes an analysis of those three levels in order to have a comprehensive understanding of the problem, and, consequently, its solution. For this study, I chose to discuss these three levels because I think it will enhance our understanding of the participants' conceptualizations and practices of empowerment. I recognize the limitations of the focus group interviews and the annual reports to provide the data for all these levels (the limitations will be addressed in the appropriate sections).

The other theoretical assumption held by Choriliaki and Fairclough (1999) concerns the conceptualization of the order of discourse, which is part of the analysis of the discourses. For them, "an order of discourse is the socially ordered set of genres and discourses associated with a particular social field, characterised in terms of the shifting

boundaries and flows between them" (p. 58). In addition, "the relationship between the discourse and the social network of orders of discourse depends upon the nature of the social practice and conjuncture of social practices it is located within, and how it figures within them" (Chourialaki & Fairclough, 1999, p. 63). Thus, the orders of discourse are particular way that social practices of a particular field are organized and depend on an understanding of the conjuncture. In my own words, orders of discourses are a particular set of practices that characterize a specific field; for example, the health promotion field can be characterized by three approaches: medical, behavioral, and socio-ecological (Labonte, 1993). Each approach embraces particular worldviews and actions and, consequently, belongs to a different order of discourses. Thus, health promoters who choose to practice from a behavioral perspective will develop, for instance, programs targeting smoking habits of a youth population (Labonte, 1994). These practices, on the other hand, will diverge from health promoters whose beliefs and actions are in line with the socio-ecological approach (these professionals would develop, for instance, strategies to combat poverty) (Labonte, 1992). However, sometimes it is not the choice of the health promoters that determines the type of actions they will put in practice, but some contextual features (e.g., funding and human resources) (Carey & Braunack-Mayer, 2009). In this study, the orders of discourse will concern health promotion and empowerment, which are the general social fields of this study.

To fit this framework with the general organization of this thesis, I have divided the framework into two chapters. Chapter 4 describes the first two steps of the CDA framework while chapter 5 presents the last three steps. The purpose of this organization

is to make explicit the division between the analytical process (the first two steps) and the interpretative process (the last steps)[6].

Approaches to Ensure Rigour

There is a great deal of debate about how qualitative inquiry scholars can guarantee the quality of a study (Angen, 2000). Despite ontological and epistemological differences among scholars from diverse qualitative research traditions, an attempt to develop a common ground of quality 'insurance' in qualitative research methodology is being demanded (Whittemore, Chase, & Mandle, 2001). However, to the best of my knowledge, this common ground has yet to be reached.

As consequence of the lack of consensus, I brought together different approaches of ensuring rigour to this study. This collage approach addresses many potential validity threats of the study and is consistent with the idea of *bricolage* advocated by Kincheloe and McLaren (2005), that is, critical researchers can adopt many ways to guarantee the quality of a study as long as they clarify the theoretical position they adopted. As such, I adopted an approach which addresses the specific design of this case study, and a reflexive strategy to guarantee rigour. It is important to note that I have adopted a notion of validity as a process and not as a set of steps to undertake (Cho & Trent, 2006). Addressing validity was ongoing throughout the study rather than a static step that was taken at the end of the research (Angen, 2000; Cho & Trent, 2006).

Approach to ensure rigour in case studies. Flyvbjerg (2004) argues that generalization (a traditional validity claim) underestimates the power of case study research. This author sustained that a case study can contribute to knowledge when it provides insights about a topic or a situation even though the context may vary between different case studies. As a result, rather than providing an objective reality of the case,

[6] It is important to note that the framework does not suggest this division; it was my own interpretation of the Chourialaki and Fairclough's (1999) framework while reflecting on the characteristics of the data that led me to conceive the division between the analyses per se and the interpretation of the data.

this study intends to provide a certain way to think and talk about the study topics (i.e., health promotion and organizational empowerment). The ultimate purpose of this study is to contribute to the scholarly discussion about these issues.

The process of selecting a case to study is also an approach to ensure quality to case studies and that "the interpretation of... a case can provide a unique wealth of information, because one obtains various perspectives and conclusions on the case" (Flyvbjerg, 2004, p. 428). The intensity sample strategy adopted in the sampling strategy ensured that a relevant case was selected. As a result, the organization selected can yield enough information to guarantee that we can learn the most from the studied case.

Triangulation can also be an approach to ensure quality of case studies. Triangulation is the use of various ways to gather data as well as clarification about how the researcher gave meaning to the data (Stake, 2005). In this study, I did not adopt the traditional concept of triangulation that seeks for confirmation of the findings and interpretations using other studies undertaken by, for example, scholars of other traditions using other methods or contexts (Seale, 1999). In contrast, I adopted the view that critical theorists should use a variety of data collection methods in order to have deep insights about the topic of interest (Kincheloe & McLaren, 2005). An effort was made to ensure that the approach to data collection included important ways to reveal the organization's understandings of empowerment.

The way in which the findings and discussion are presented is also important for case study research. Flyvbjerg (2004) argues that summaries of case studies are both difficult and undesirable. Instead, the researcher should treat the case study as a story-telling process. Humphreys (2005) points out that the validity of research is in the meaning the researcher gave to the data and not in the accuracy of the story. To that

end, in the next chapter I provide a description of the studied organization. In addition, to write a good story, the researcher should be close to the research participants because the process of giving meaning to the research findings is "prescribed in the act of being in the world, the research process, and objects of research" (Kincheloe & McLaren, 2005, p. 319). The collaborative approach to the research was an attempt to be close to the participants. In the next section, I discuss the reflexive approaches I adopted to ensure rigour.

Reflexive approaches to ensure rigour. For Patton (2002), the characteristics of the researcher are also important to guarantee rigour to the study because the researcher is one of the instruments of the qualitative research. One of the ways to specify the characteristics of the researcher within the research process is to develop a self-reflexive journal to document the conceptual development of the research. In addition, the reflexive journal, according to Angen (2000), "provides evidence of how the conclusions were reached" (p. 390). As a result, during the research process I kept a reflexive journal. Also, I have met regularly with my thesis advisory committee to obtain feedback on the progression of this.

Angen (2000) suggests ethical validation as a way to guarantee trustworthiness for research using the qualitative research paradigm. To achieve ethical validation, "[researchers should] ask if the research is helpful to the target population, if there are alternative explanations than the ones settled on, and if we [researchers] are more sensitized to, or enlightened about, the human condition because of the research" (Angen, 2000, p. 389). To guarantee trustworthiness, researchers need personal involvement with the research process, an ethical position inside the setting, and an ability to close the gap between themselves and the researched (Angen, 2000). Thus, the fact that I opened the first draft of the data analysis for the participants aimed to ensure

ethical validation. Also, during the development of the objectives and purpose of the study, I strived to ensure that the research would be relevant not only for the studied organization, but also for the field of study.

In general, critical theorists believe that an objective social reality does not exist (Kincheloe & McLaren, 2005). Smith and Hodkinson (2005) agreed when they stated, "[we] must acknowledge that we are in the era of relativism" (p. 915). For this reason, researchers should be explicit about their personal and theoretical background to guarantee the goodness of the study (Kincheloe & McLaren, 2005). Indeed, Freire (1998) affirmed that the individual who observes a situation do it from a certain point of view (which in research language can be described as bias). For Freire, the person's point of view is not the source of observational inaccuracies; instead, the source of error is to consider this point of view the only perspective acceptable and not acknowledge that there are other viable perspectives. This study is a perception and reflection on the topic of empowerment and health promotion and not an objective reality. Also, the reflexive journal and the detailed representation of the researcher described above also ensured that this study concurred with this approach to ensure rigour.

Ethical Considerations

In accordance with University of Western Ontario Health Science Research Ethics Board, I applied and received ethics approval (see Appendix C), and abided by the guidelines related to issues of informed consent and confidentiality.

There were no known physical risks to participants from this study. Due to the face-to-face and collective nature of the interview, participants might have felt uncomfortable to discuss the topic of the research. Also, the fact that the focus groups were conducted in the organization's facility could add some kind of discomfort. I attempted to minimize any discomfort by giving explanations of the purpose and

process of the research, as outlined in the Letter of Information (Appendix D); in addition, I conveyed information regarding confidentiality for the participants. Participants were free to ask to stop the audio-recording and leave the group meeting at any time without any harm to their employee status. No compensation was provided to the participants upon completion of the study.

It is a challenge to guarantee confidentiality when conducting focus groups because the researcher cannot assure this on behalf of other participants (Culley, Hudsong, & Rapport, 2007). Tolich (2009) warned that group interaction within participants of the same organization deserves special attention to ensure confidentiality. For both Culley et al. (2007) and Tolich (2009), the way to address this issue is through the letter of information and informed consent. A Letter of Information (Appendix D), which was given to all participants before the focus group, explicitly informed the participants about the limitation of confidentiality insurance within group interaction and their responsibility in ensure confidentiality to maintain a trustful climate. Once the participants confirmed that they had read and understood the Letter of Information and had their questions answered, they were asked to sign an informed consent form (see Appendix E).

Audio-recorded sessions were transcribed verbatim by me and revised by an English language user, who worked under a nondisclosure agreement. Names and positions of the participants and other employees, as well as the name of the organization, if disclosed during the focus groups, were deleted in the transcription. It is important to highlight that I chose to not disclose the name of the organization in this final report. In the initial conversation with the gatekeepers, my supervisor and I questioned the gatekeepers if the organization would wish to disclose its name in the final report. At that time, the gatekeepers promised to think about but no response was

given. Due to time constraints, I was not able to continue this conversation before the application to the ethical clearance. Thus, unaware of the organization's decision, I chose to maintain its anonymity. This fact has also implications to the description of the case study, but I will comment on this matter in the next chapter. The UWO REB guidelines regarding confidentiality and data storage were dully followed.

Conclusion

In sum, this case study aims to provide insights on organization's understanding and practice of empowerment. Two focus groups with organization's members and analysis of organization's annual reports provided the dataset for this study. The adoption of a critical discourse analysis approach has the potential to enhance our understanding of those processes and the context in which these processes are included. In the next chapter, I present the first two steps of the CDA framework.

Chapter 4: Critical Discourse Analysis

This chapter describes the results of the critical discourse analysis (CDA) performed in two focus groups (one comprised of staff members and the second of board members) and nine annual reports from the studied organization. I utilized Chouliaraki and Fairclough's (1999) CDA framework to guide this analysis (see Chapter 3: Critical discourse analysis framework). Practical guidance in how to undertake the framework was also provided by Fairclough (2001, 2003a). As pointed out earlier, this chapter addresses the two first steps of the framework: (a) the problem and (b) obstacles to the problem being tackled. Appendix I shows a visual representation of the steps and sub-steps of the CDA framework.

Step 1: The Problem

Chouliaraki and Fairclough (1999) asserted that any textual analysis should focus on a problematic aspect of social practices. A number of problematic aspects of the social practices in health promotion and organizational empowerment were pointed out in previous chapters. However, here I reiterate some issues that are central to this analysis.

Health promotion organizations are generally resistant to change practices toward more empowering approaches (Laverack, 2004). Reasons for this resistance may include the lack of a shared understanding of empowerment among the organization's members and the influence of funding agencies in the organization's activities. This study focuses on whether a lack of a shared understanding of empowerment conceptualization among professionals of a health promotion organization is problematic for their practices of reducing health inequities. The organization's understandings and practices of empowerment will be underscored.

Step 2: Obstacles to the Problem Being Tackled

This step of the framework intends to analyze "how the problem arises and how it is rooted in the way social life is organized, by focusing on the obstacles to its resolution – on what makes it more or less intractable" (Fairclough, 2003a, p. 209). Thus, the focus here is on obstacles toward a shared understanding of empowerment among professionals of health promotion organization and the practices of this understanding in the resolution of health inequities.

Chouliaraki and Fairclough (1999) recommended three ways to examine the obstacles to solve the problem, as follows:

(a) Analysis of the conjuncture – this sub-step aims to examine the broad context of social structures (a macro-level analysis);

(b) Analysis of the practices – this analysis focuses on relationships that constitute the social practices (a meso-level analysis);

(c) Analysis of the discourse – this sub-step examines specific social events that are translated into texts (a micro-level analysis).

For Fairclough (2003a), these three levels of analysis are dynamic and interrelated, and they influence and are influenced by each other. While recognizing their interconnections, I now address each one of these sub-steps.

Analysis of the conjuncture. The analysis of the conjuncture provides "a broad sense of the overall frame of social practice which the discourse in focus is located within" (Chouliaraki & Fairclough, 1999, p. 61). For these authors, this sub-step allows the analyst to examine the influence of "conjuncturally linked series of events in both sustaining and transforming (rearticulating) practices" (p. 22). Ultimately, the link the analyst makes between the discourses and the conjuncture of the current social practices determines the interpretation of the discourses in focus.

For this sub-step, I provide an overview of the history of the organization because it helps to contextualize its current practices. Furthermore, the current structure of empowerment (the broad discourse in focus) and health promotion (the main studied social practice) are also addressed. I also present the components of organizational empowerment (OE), as developed by Peterson and Zimmerman (2004), because they help to characterize the organization. Finally, in light of the context in which the organization is embedded, I will outline the orders of discourses utilized in this analysis. To illustrate this analysis of the conjuncture and the following analyses, I chose to provide direct quotations (identified by quotation marks) from the raw data (the focus groups' transcriptions and the annual reports) in order to give a sense that the participants and the organization are speaking for themselves. The transcriptions symbols I utilized are described in the Appendix H.

The history of the studied organization. The material I utilized to investigate the history of the organization were: (a) the first external evaluation of the organization provided by a staff member (written one year after its foundation), (b) information displayed in the organization website, (c) the organization's annual reports, and (d) two articles published in a peer-reviewed journal[7], written four years after the organization's foundation. To guarantee the anonymity of the organization, I will not reference these sources and some information (i.e., the year of foundation, number of employees, and some specific milestones) will not be disclosed. Although I grant that the lack of this information might limit the readers' knowledge about the case[8], the information provided is probably enough to offer a good description of the organization.

[7] These articles were written by a group of external evaluators together with the organization's executive director of that time and published in the same issue of a scholarly journal.

[8] Generally, researchers adopting case study designs are encouraged to provide a comprehensive description of the studied setting in order for the readers understand the relevancy of the case (Caronna, 2010; Stake, 2005).

The organization was founded in the 1980s by two federal ministries in a historic moment where various organizations were created across North-America with a purpose to disseminate knowledge about prevention of diseases. At that time, there was an expansion of prevention of diseases programs across Ontario. Many agencies, communities, and individuals were willing to develop, implement, and evaluate health promotion interventions. Also, there was a general idea that the availability of information about diseases prevention and knowledge exchange among professionals, communities, and researchers was necessary to improve the number and quality of health promotion interventions across Ontario. This idea culminated in a project regarding the creation of an organization with the mandate to be a center of dissemination and exchange of health prevention information. Under the pressure of a group of advocates comprised by researchers and practitioners, the federal government agreed to fund the institution.

Since its creation, the activities of the organization have evolved, but the dissemination of health information and knowledge exchange are still essential roles of the organization. Confirming this idea, during the focus group, a staff member said that "a lot of our services have now been described under (…) you're either exchanging information, doing consultation, giving a workshop or networking". To that end, the organization produces many health promotion resources (e.g., pamphlets, brochures, and toolkits) and interactive exchange of knowledge with its clients (e.g., workshops, presentations in conferences, and consultations) about a variety of topics, including specific condition (e.g., stroke and others cardiovascular disease and fetal alcoholic disease) and broad societal issues (e.g., social determinants of health and health equity). The clients of the organization include what some participants of the focus groups called health intermediaries: health organizations and health professionals.

As noted in the organization's annual reports, the organization has increased over the years the number of staff, the services provided, the funding resources, and credibility with clients and partners. According to its website, the organization works in both official languages and has programs, partners, and staff distributed across Ontario and Canada. Currently, the organization is heavily supported by provincial and federal governments (or government agencies), but funding also comes from private agencies and partners.

Providing the context in which the organization was created and its current practices is important to understand its position within the larger provincial health promotion structure. In the next section, I provide a general context of health promotion and empowerment by bringing together the current literature on these topics and contributions of the participants of the focus groups.

Health promotion and empowerment conjuncture. Much of the conjuncture of empowerment processes within the health promotion field was discussed in previous chapters; nevertheless, it is worth to recall some central points. The hegemony of the medical and behavioral perspectives over socio-ecological approaches in health promotion interventions is recognized (Guldan, 1996; Laverack, 2009). Because of this hegemony, interventions that adopt socio-ecological approaches to health promotion are generally neglected (Laverack, 2004). Empowerment strategies are conceived within the socio-ecological approach to health promotion because it considers the influences of individual and social, political, and environmental factors on people's health (Labonte, 1993). As a result, despite the growing awareness of empowerment strategies among health promotion researchers and practitioners, this knowledge has not been translated into practice (Laverack, 2004). As little socio-ecological research and programs are put in practice, the resolution of health inequities is in jeopardy (Marmot, 2009).

Some focus groups' participants agreed with some of these claims. During the focus group with board members, participants agreed that, in the current "health promotion thinking", there is an emphasis on the "traditional medical model". In the same token, a participant in the staff members' focus group stated that current health promotion is "more medicalized" than at the time the organization was founded.

For many scholars, the financial structure of health promotion programs affects the way organizations and health promoters operate empowerment strategies (G. E. Carey & Braunack-Mayer, 2009; Minkler, 1985; Wallerstein & Freudenberg, 1998). Since governments are generally responsible for organizing and supporting the health system (Health Canada, 2010), the funding for health promotion activities (including empowerment strategies) are under political mandates. Consequently, political structures influence the way health promotion and empowerment interventions are put in practice (P. Carey, 2000; Friel, Bell, Houweling, & Marmot, 2009; Raphael, 2003b). The participants of the focus groups in this study also highlighted these issues. During the board members' focus group, there was a general agreement that "part of the issue is the ((politicians')) willingness to hear" the success of empowerment strategies within health promotion programs. Some staff and board members were also critical of the current governments' support for health promotion and empowerment strategies. A board member said that "when you're using public money (...) there is always a sort of tension. You have to work within your funding mandate". This makes clear that the funding mandates of the organization impact empowerment strategies because, as a board member put it, "if ((empowerment)) is not in their ((politicians)) value set", they will not support this type of strategy.

A salient point was made by another board member, who considered that the problem is not on the government's support for health promotion programs, but on the

government's definition of health promotion. This individual argued that government's definition of health promotion is limited to "sports and physical activity" and health promotion programs should go beyond this approach. Thus, for this participant, the problem is not the financial support for health promotion, but the politicians' conceptualization of health promotion. This board member's argumentation is also in line with the idea that medical and behavioral approaches are hegemonic within health promotion programs since the "sports and physical activity" are considered under the behavioral approach to health promotion (Labonte, 1996).

As an example of the impact of the government support to the organization's activities (and the sense of empowerment within the organization), a staff member articulated that there was an occasion in which the organization was "surprised by the government's decisions" to withdraw funding for an organization's programs. This participant went on to say that "it did impact (...) the organization. (...) there was a high level of insecurity" and the staff was not feeling valued and supported. Since the organization is mainly funded by provincial and federal governments, this example demonstrates that governments' political orientation and priorities impact the organization's funding, which, in turn, affected the organization's activities. In brief, the board members generally agreed with the idea that the current political and financial contexts do not support health promotion programs from a socio-ecological perspective. Also, the example given by a staff member also illustrates the influence of this context on the organization's activities.

In the next section, I introduce an organizational empowerment framework that contextualizes the organization's discourses and practices.

Organizational empowerment: A framework. While individual empowerment and community empowerment are concepts that are widely discussed in the health

promotion field, as identified in the literature review, this field seems to neglect organizational empowerment (OE) processes. In an attempt to foster the study and development of OE strategies within the health field, Peterson & Zimmerman (2004) have created an OE nomological framework. This framework was described fully in Chapter 2, so in this section I only highlight the components of the framework. For the authors, OE strategies have three components: (a) intraorganizational, (b) interorganizational, and (c) extraorganizational. Within each component, there are specific processes and outcomes that help to identify *empowering* or *empowered* organizations. Empowering organizations are those that satisfy the intraorganizational component of OE and empowered organizations are those that satisfy all three components (Minkler, Thompson, Bell, & Rose, 2001; Peterson & Zimmerman, 2004). Although I admit that these components and processes do not address some important aspects of empowerment (i.e., the power relations between the organization and the funding agencies), they are useful when analyzing the orders of discourses.

Orders of discourse. Based on this analysis of the conjuncture, I now can set the health promotion and organizational empowerment orders of discourse. For Chouliaraki and Fairclough (1999), discourses work within a certain network of social practices, which are described by the orders of discourse. This means that there are certain theoretical constructs and practices within each order of discourse (Fairclough, 2003a). To represent the organization's practices and ideas on health promotion, in light of the Labonte's (1993) three perspectives of health promotion, I have identified three orders of discourses: (a) medical perspective of health promotion; (b) behavioral perspective; (b) socio-ecological perspective. For organizational empowerment, according to Peterson and Zimmerman's (2004) components of OE, I also identified three orders of discourses: (a) intraorganizational, (b) interorganizational, and (c) extraorganizational.

These orders of discourse will be important to the analysis of the discourses described below.

Summary of conjuncture's analysis. This section examined the context of the organization under study. I highlighted that the organization activities can be described as, according to a staff member, "exchanging information, giving a workshop or consultation" about health promotion issues. Also, according to some staff and board members, the organization feels the effects of the current dominance of the medical and behavioral approaches to health promotion on their activities and the government's influence on its practices. As part of the analysis of the conjuncture, I also presented the health promotion and organizational empowerment orders of discourses which will further help to characterize the participants' discourses. In what follows, I introduce the second sub-step of the analysis of the obstacles to address the problem.

Analysis of the practices with reference to its discourse moment. This step of the framework examines how the analyzed texts come to be produced in terms of the moments of social practice[9]. Chourialaki and Fairclough (1999) identified four moments of social practice: "[a] material activity (specifically non-semiotic, in that semiosis also has a material aspect, for example, voice or marks on paper); [b] social relation and processes (social relations, power, institutions); [c] mental phenomena (beliefs, values, desires); and [d] discourse" (p. 61). The objective of the analysis of practices is to "specify relationships between discourse and the other moments" (Chourialaki & Fairclough, 1999, p. 61). It is important to emphasize the interplay between those moments. For Chorialaki and Fairclough (1999), ontologically, it is pointless to conceive a material activity without a mental phenomenon involved in doing that, or a discourse without a social relation involved in this practice. One should

[9] Moments of social practice are "elements of life [that] are brought together into a specific practice" (Chouliaraki & Fairclough, 1999, p. 21).

analyze these moments in relation to one another in order to have a sense of the whole practice. Since the practices that produced the focus group texts are different from the practices of designing annual reports, I will discuss them separately.

Analysis of the practices: the focus groups. The focus group interview sessions were part of a research project, in which the participants were given the opportunity to orally express their thoughts on a certain topic proposed by a researcher, which were later transcribed into a text. For this text to be produced, both the researchers and the participants engaged in a series of social relations, which influenced the dynamics of the focus groups.

I made the first movements toward the focus groups interviews: I designed the research project, selected a potential organization, and invited its members to participate in the study. This fact demonstrates a passive role of the organization and the power of the researcher in determining the direction of the project. I was also considered to be an outsider because I did not know the organization or any of its members before the research process.

To turn the research project into reality, some of the organization's members, my supervisor and I engaged in a series of communication events both in distance (emails and telephone calls) and in person (meetings at the organization's office). Although I admit that the time span between the first contact with the organization and the focus group interviews was short (about four months), the time was enough to construct a sense of trust and collaboration necessary to make the focus groups happen. Previous to the focus groups, my supervisor and I had met only two participants (specifically the two gatekeepers) out of the eleven individuals who participated. Thus, we maintained our outsider status. The social relationships among the participants of the focus groups are important because they shape the interaction during the focus groups. That said, I

am not able to fully analyze their social relations because it was beyond the scope of this research to gather data on that (more details on this topic is in Chapter 5).

The third moment of social life is the mental phenomena, which refers to participants' beliefs and motivation of their involvement in the production of the texts. From a researcher's perspective, I believe that the reflexive approach to the research described in the Chapter 3 detailed my personal values and beliefs that affected the conduction of the focus groups. In respect to the mental phenomena of the participants of the focus groups, some comments can be made based on the answers of the initial question of both focus groups: "What brought you here ((to this focus group))?" From the diverse answers to this question, I identified some explicit and implicit motivations. Explicitly, some staff members voiced that they wanted to "reflect" on the research topic – empowerment in general and organizational empowerment, more specifically. Another staff member felt the need to "help the team to provide a ((empowerment)) perspective that wasn't so straight from the health promotion perspective". A participant of the staff focus group desired to see in practice what this individual was "learning in school". One staff member and one board member were "curious" to know the other's conceptualization and experiences of empowerment. A board member wanted to see the researcher's "assessment" on empowerment issues within the organization. Lastly, another board member desired to contribute to the research.

Implicit motivations to participate in the research project included a desire to challenge the current practices of empowerment from an organizational perspective. A staff member questioned the organization's role within the empowerment and health promotion contexts. In brief, participants and researchers had many motivations, beliefs, and desires to be part of this study, which impacted the way the focus groups were conducted and framed the interactions of the participants. Also, the focus groups were

research practices, which mean that I had the power to frame the interview process and, consequently, the analysis.

Analysis of the practices: The annual reports. The collection of the annual reports is a discursive practice (an overview of the organization's activities in a designated year) which is translated into material activity. It was beyond the scope of this study to gather details on how the annual reports were produced to elaborate on the social relations among the individuals who wrote the reports, the other members of the organization, and the audience of the report, not to mention the mental phenomena involved in designing the report. However, I asked one organization's member about the process of designing the annual reports and this person said that the "Executive Director typically writes the annual report; drafts are reviewed by the other managers and often their input is gathered up front to help identify the key areas to highlight". The organization also hires an editor "to help with the overall tone and flow" of the report. The chair of the board of the directors also reviews the report before it is released. Thus, although many people help to design the annual report, the main responsibility for producing the annual reports lies with the executive director. This fact demonstrates the centrality of this position within the organization structure and the power of the executive director in projecting the image of the organization through the annual reports.

Summary of the practices' analysis. This section provides a sense on how the analyzed texts influenced and were influenced by the moments of social practice. This means that the focus groups meetings and the annual reports were not just discursive practices or material activities; they internalized other moments of social practices, such as the mental phenomena and the social relation of the participants and the researchers. The social relations that took place during the production of the texts are relations of

power because the executive director has power over the design of the annual reports. Similarly, the researchers have power over the conversation that happened during the focus groups. The participants of the focus groups had a varied of reasons and motivations to participate in the discussion. Thus, the focus group interviews and the annual reports are the result of different social practices and relationships and this should be explicit when one analyzes and interpret the focus groups interviews and the annual reports.

In what follows, I address the final sub-step of the analysis of the obstacles to the problem being tackled – the analysis of the discourses identified in the focus groups and annual reports.

Analysis of the discourses. According to Chouliaraki and Fairclough (1999), the analysis of discourse aims to identify the elements of the texts (e.g., themes, genres, discourses, and vocabulary) in order to examine their interconnections with the orders of discourses. For the authors, analyzing discourses includes a structural dimension and an interactional dimension. From a structural perspective, the role of the analyst is to identify the set of themes, genres, discourses, and voices that can be identified within the studied texts. In explaining about the themes identification, Fairclough (2003a) writes,

> in textual analysis one can... identify the main parts of the world (including areas of social life) which are represented – the main 'themes;'... Each of these themes is open in principle to a range of different perspectives, different representations, different discourses. (p. 129)

The structural dimension of discourse analysis also includes the identification of the genres, discourses, and voices in the texts. Chouliaraki and Fairclough (1999) explain,

> we use the term 'genre' for the sort of language (and other semiosis) tied to a particular social activity, such as interview; 'discourses' for the sort of language used to construct some aspect of the reality from a particular perspective, for example the liberal discourse of politics; and 'voices' for the sort of language used by a particular category of people and closely linked to their identity, for example the medical voice. (Chouliaraki & Fairclough, 1999, p. 63)

Furthermore, in this dimension analysts should "locate the discourse in its relation to the network of orders of discourse" (Chourialaki & Fairclough, 1999, p. 62). More details on the meaning of genres, discourses, and voices will be provided in the appropriate sections.

The interactional dimension is a second perspective for analyzing discourses. The focus of this dimension is on the linguistic features of the texts such as semiotics, and grammatical features (Chouliaraki & Fairclough, 1999). In this dimension, "language connects meaning (the semantic stratum) with their spoken and written expressions (the stratum of phonology and graphology). Both meanings and expressions interface extra-linguistic – meanings with social life, expressions with for instance bodily processes" (Chouliaraki & Fairclough, 1999, p. 139). Although the expressions (phonology and graphology) do not "directly interface with the social, it is historically shaped through processes of semogenesis – the historical production and change of the semiotic – which open the language system to social shaping" (p. 139-140). Thus, the analysis of discourse from an interactional perspective may provide insights on the how social structures influence social events in its inner forms (e.g., vocabulary, and body language). Fairclough (2003b) demonstrated that diverse fields of knowledge such as media and education, for example, are adopting neo-liberal vocabulary (e.g., globalization, flexibility, and customer) which shows that the media and educational

fields are incorporating not only the neo-liberal language, but also the neo-liberal values (Fairclough, 2003b). Although I recognize that this type of analysis would enrich the study with insights about the interplay between language, power, and discourses, this study disregards this perspective. As a second language user of English and a non-specialist in linguistics, I think that my analysis would not have a proper depth. However, whenever possible, I will focus on the vocabulary specificities of the texts.

In what follows, I firstly present the analysis of the discourses of the focus groups interviews and secondly the annual reports with a focus on the structural dimension (i.e., the identification of the themes, genres, discourses, and voices). Note that I developed the themes, genres, discourses, and voices with the assistance of the diagrams designed in the technical portion of the analysis (see Appendix G). After close and repetitive readings of the raw material and feedback from my advisory committee, I developed the final themes, genres, discourses, and voices presented below.

Analysis of the discourses: The focus groups. Figure 4 summarizes the focus genre, themes, discourses, and voices. I address each component in turn.

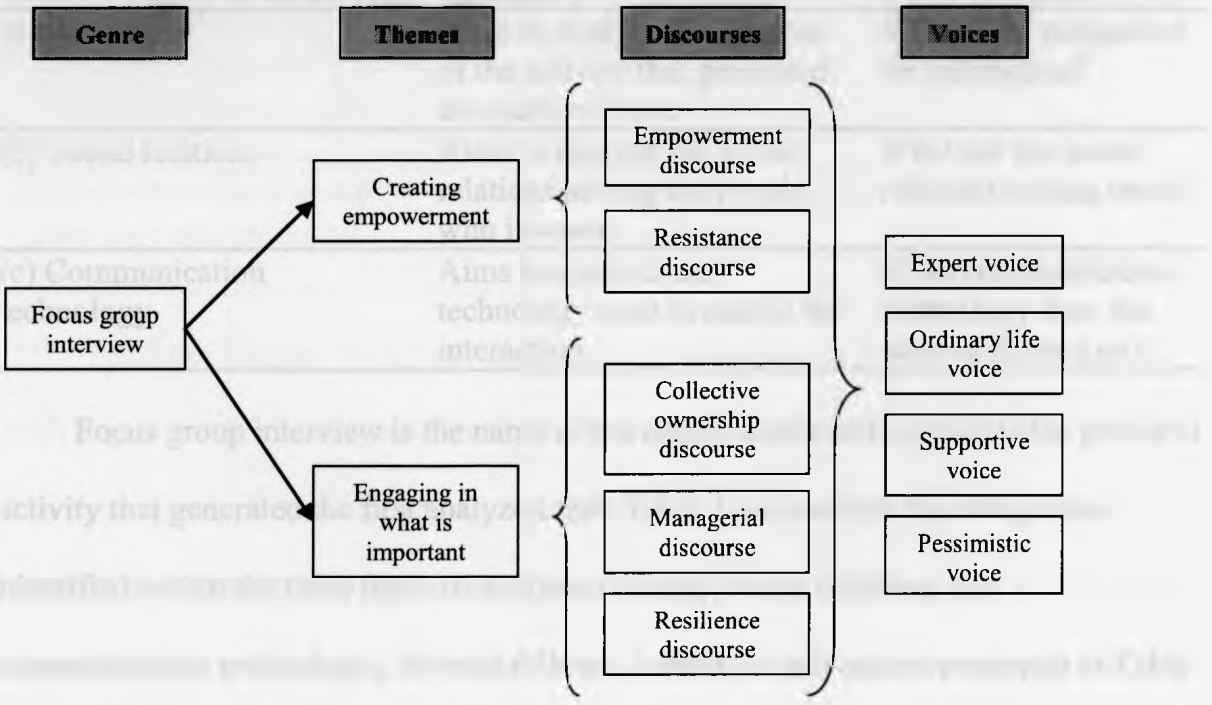

Figure 4. Genre, themes, discourses, and voices identified within the focus groups.

Focus groups' genres. According to Fairclough (2003a), "genres are the specifically discoursal aspect of ways of acting and interacting in the course of social events" (p. 65). He went on to say that one can analyze the genres in terms of (a) activity, (b) social relations, and (c) communication technology (see Table 1). Activity relates to the purpose of the social interaction that generated the analyzed texts (in the case of this section, the focus groups); social relations analysis focus on the relationship between the people who interact to produce and consume the text; and communication technology is concerning the technology that was applied to enable the communication. I also included the Lehoux, Poland, and Daudelin's (2006) analytical template for focus group research to help in the conduction of this genre analysis (see Appendix J). This template is relevant to the genre analysis because it sheds light to some specific activities and social relations features of focus groups, which are obscured in the three perspectives on genre analysis framed by Fairclough (2003a).

Table 1

Three Perspectives on Genre Analysis According to Fairclough (2003a)

Genre analysis in terms of:	**Summary**	**Basic question**
(a) Activity	Aims to analyze the purpose of the activity that generated the analyzed text.	What is the purpose of the interaction?
(b) Social relations	Aims to analyze the social relations among the people who interact.	What are the social relations among them?
(c) Communication technology	Aims to analyze the technology used to enable the interaction.	What communication technology does the activity depend on?

Focus group interview is the name of the central genre and represents the principal activity that generated the first analyzed text. Table 2 summarizes the sub-genres identified within the three focus of analysis (activity, social relations, and communication technology). In what follows, I detail the sub-genres presented in Table 2 and illustrate them with quotations from the focus groups.

Table 2

Summary of the Focus Groups' Genres

Activity	
Participants' purpose:	*Researchers:*
– Reflection	– Academic
– Helping	
– Curiosity	
– Assessment	
– Learning	
– Contribution	
– Challenge	
Social relation	
Staff members focus group:	*Researchers:*
– Colleague/ friendship relationship	– Experienced
– Diversity in role within organization	– Directing the interaction
– Shared vision	– Active interaction
– Experienced social status	– Challenging common ground
– Knowledgeable social status	– Outsider social status
– Short acquaintance with empowerment	*Board members focus group:*
– Grandmother social status	– Supporting role within the organization
– Novice social status	– Homogeneous group
– Active interaction	– Constructive interaction
– Passive interaction	– Set directions
– Old staff interaction	
– New staff interaction	
– Constructive interaction	
Communication technology	
Staff members focus group:	*Board members focus group:*
– Two-way non-mediated interaction	– Two-way mediated interaction

The focus groups' texts were generated in a voluntary and non-ordinary meeting with organization's members with a specific purpose of satisfying my research goal[10]. The participants of the focus groups also had interests in participating in the research. Again, I am not able to further discuss on this matter due to limitations of the gathered data. However, the analysis of the mental phenomena in the "analysis of the practices"

[10] This study also aims to satisfy a requirement of a Masters of Sciences degree.

section above partially addresses this issue and, for this reason, I reproduce them in Table 2.

The analysis of social relations is complex and an in depth analysis of the participants' relationship cannot be provided because it was beyond the scope of this study. Instead, this analysis will focus on some information voluntarily disclosed during the focus groups.

The first focus group was comprised by staff members whose roles are to operationalize the organization's activities. The staff members who participated in the research project regularly meet with one another in the office[11]. During the staff focus group, the participants demonstrated a personal connection among them: "we are all colleagues here". However, some comments implicitly communicated that they are not only colleagues, but also they are personally related: "when you work with somebody it's really good to know them". The widespread use of the pronoun *we* also exemplifies this colleague and friendship relationship: "I like the approach that we have"; "We enjoy working with each other". In addition, the pervasive usage of the pronoun *we* helps to construct a common ground, a sense that everyone is talking in a collective sense, not an individual sense.

Also relevant to the social relations among the participants of the staff focus group is their position within the organization. To protect their confidentiality, I am not able to disclosure the role of each participant; however, I can say that a good variety of positions was present in this focus group. Two participants made clear that their work was not "a direct work with people (...) through health promotion (...) outside the organization". Other participants, in contrast, clearly stated that their work was related

[11] Although the organization has a central office, not all staff members work in the same place. Some staff members work in other locations. All the participants of the first focus group are based in the central office, even though invitation to participate in the focus group was sent to all staff and a teleconference system was available for those who could not participate in person.

to the health promotion. Despite that the participants have different positions within the organization, there was a sense that the participants shared a common vision, as one participant has argued: "we are all working with the same vision, in some ways we are". This means that the social relations among the participants are also characterized by a shared vision.

The varied composition of this group provided grounds for diversity in respect to participants' experiences with empowerment concepts, which also shapes the social relation among the participants during the focus group. In the Letter of Information (see Appendix D) I purposively did not require that the participants had previous practical experience with empowerment interventions, although we expected that the participants had some familiarity – in a broad sense – with this concept. In doing that, I aimed to include as many perspectives as possible in which, I believe, the project succeed. For example, some individuals were aware of concepts of empowerment for many years ("over the years, ((empowerment)) has been a concept that we've talked about"). Other members related their empowerment experiences with a previous work with "grassroots groups". Another staff member said "I'm learning ((about empowerment)) in school". Further, one staff member demonstrated to be knowledgeable about empowerment by defining this concept: "((empowerment)), at its heart, it is about the sense of control that one feels or has over parts of their life and hopefully all of their lives". Contrasting with this last participant, a staff member seemed not so familiar with the concept of empowerment: "I know that there is a concept of empowerment that relates to issues of control (...) I heard a presentation from ((another country)) at a conference". It is important to highlight that although this staff member disclosed a little acquaintance with the conceptualization of empowerment, this person did not refute the knowledge claim made by the staff member who tried to define empowerment. Ultimately, this

focus group was comprised by people with different levels of experience of empowerment (from knowledgeable to novice), but as a whole, participants did not try to impose their understanding of empowerment over the others.

Another point that impacted the interaction among the participants is the fact that the group seemed to be divided by the *old* and the *new* staff members[12]. Both the old and new staff members acknowledged this position ("there's a point where you start to feel like the grandmother"; "I've been here for a couple of years"). It should be noted that the experience status was not influenced by this division between old and new staff. For example, one staff member that disclosed his previous experience with empowerment has been working at the organization for few months.

The old staff members contributed actively and confidently to the focus group and provided the longest speeches but they did not seem to dominate the conversation or attempt to put more value to their contribution over the new staff members[13]. While some new staff members were eloquent, one particular participant seemed reserved (indeed, this individual was the newest staff member). Another participant entered the conversation when the facilitator asked for this individual participation by saying "we didn't hear you yet". After, this participant was more active in contributing to the interaction.

Also representative of the type of interaction among the participants of the staff focus group was the fact that there were few times in which a participant interrupted others' speech or were talking at the same time; in addition, the participants themselves posed questions ("I do have a question") or refuted some claims made during the discussion ("I don't think that, you know, we have really used that concept much in our internal discussions"). During the staff members focus group, there were only a few

[12] Old staff refers to individuals who have been working in the organization for more than 5 years. New staff members are the employees who work there for less than 5 years.
[13] In fact, no participant seemed to intend to dominate the conversation.

times in which the participants responded directly to other participants contribution ("I think ((participants' names)) were alluding to the fact that"). The staff members tended to support one another's statements with "yeah", "uh-hum", "good point", without further development. In doing that, the staff members maintained a positive relationship among them, but few participants built their speech around the others' statements.

The second focus group was comprised by members of the board of directors that have the role to govern the organization's activities. This group was different from the first group in many aspects. First, the participants did not have the board member activities as their primary activity. All the participants of the focus group are responsible for another activity in the health promotion field beyond what they do at the organization. Second, the social relations among the board members are influenced by the way they perceive their role within the organization. During the focus groups, the board members agreed that they work as a "resource" for the executive director and the other staff. Furthermore, one board member articulated that the board members are "someone who (...) can balance ideas off when issues come up whether it's financial (.) or trademark or a philosophical dilemma around how to go with health promotion". The participants of this group also concurred that their role is to "pass the budget and (...) make sure that the finances of the organization are intact". The board members also endorsed the view that they should "bring their own network (.) having contacts with people outside the organization (...) can be helpful". Therefore, the board of directors has a broader role of supporting the organization.

The board members' focus group was more homogeneous in respect to the previous experiences with health promotion and empowerment because all the participants claimed that they have practical experience with empowerment strategies

within health promotion[14]. These facts helped to maintain a common ground among the participants. However, in some moments, the participants relied on statements such as "To me, this is just my perspective", which implies a more individual perspective. Indeed, in the second focus group the participants used *we* less than the staff members, which might mean that the board members avoided generalizing their statements.

Although they challenged one another's statements (more often than in the staff focus group), in general the atmosphere was constructive and positive. Differently from the staff focus group, the board members replied more often to other members' statements ("It's interesting to hear what ((participant's name)) said") which also contributed to construct a common ground among the participants. The fact that no participant seemed to lead the conversation also added to the common ground. The board members also set the direction of the conversation by complaining about some comments ("I would agree with such statement but I don't [*sic*] said that") and selecting the topic of the conversation ("Let's go back to the politics").

It is also true that the facilitators of the focus groups actively participated in the conversation and, consequently, set the tone and changed the direction of the interaction by:

(a) asking many questions (e.g., "What brought you here? What is your understanding of empowerment?");

(b) commenting on the participants' contributions (e.g., "The issue of measurement is a complicated one, right?");

(c) re-setting the flow of the conversation (e.g., "Like I said two Brazilians leading the group will not be very systematic");

[14] The board members, however, have different academic and professional backgrounds.

(d) presenting themselves as experienced in health promotion; interacting with the participants (e.g., "I totally agree"); and

(e) suggesting summaries of the contributions (e.g., "so, ((empowerment)) always have to be in relation to another thing?").

It was also clear that the facilitators tried to challenge the common ground ("There are no clashes between the way you work here and between the people who work over there?") and positioned themselves as outsiders in relation to both the organization and the country.

The last point of the genre analysis regards the communication technology utilized to enable the group interactions. Fairclough (2003a) classified four types of interactions: "(1) Two-way non-mediated: face-to-face conversation; (2) Two-way mediated: telephone, email, video conferencing; (3) One-way non-mediated: lecture, etc; (4) One-way mediated: print, radio, television, Internet, film" (p. 77).

In the staff members' focus group, all participants were in person during the meeting; therefore, it was a two-way non-mediated interaction. In contrast, the board members' focus group was a two-way mediated interaction because, due to unforeseen circumstances, all the participants utilized a teleconference system to contribute to the group. This has important implications for the research because, although the teleconference system enabled the realization of the focus group, the participants were not able to relate with the gestural or facial expressions of the others, which is a characteristic of the non-mediated interactions (Fairclough, 2003a). Ultimately, the interaction in mediated conversations lacks some relevant gestural and facial features to conversations that might affect the group dynamic.

Summary of the focus groups' genres. The previous section demonstrated the network of genres identified in the focus groups and provided an overview of the social

activity and relations that took place during the construction of this text as well as the communication technology that mediated the interaction. In brief, the staff members maintained a positive atmosphere during the focus group despite of the differences in position and time in the organization they themselves disclosed. The board members also kept a positive atmosphere, even though the participants' challenged one another's statements. The focus group with the board members was unique because of the fact that a teleconference system was utilized to enable the conversation. In the next section, I continue the discourses analysis by examining the themes identified in the focus groups.

Focus groups' themes. Considering the entirety of the discourses produced by the two focus groups, I have identified two themes in the focus groups: (a) creating empowerment, and (b) engaging in what is important. The first theme encompasses the way the participants elaborated their conceptualizations of empowerment. In addition, ideas and beliefs the participants have indicated that affect the organizational empowerment process are included in this theme. The second theme represents how the participants' understanding of empowerment is reflected into their practice. Each of these two themes represents a particular focus of this study although the themes are intrinsically related. In what follows, I present the discourse identified in each theme, beginning with the theme creating empowerment.

Discourses of the theme creating empowerment. In Chapter 3 I defined discourse from two complementary perspectives. The first perspective, as proposed by Cheek (2004), embraces discourse broadly, as the "discursive frameworks which order reality in a certain way" (p. 1142). In the second perspective, discourses are specific textual elements (e.g., expressions of ideas and vocabulary) utilized by individuals to construct their reality (Fairclough, 2003a). For this analysis, researchers should adopt the second

perspective of discourse (Chouliaraki & Fairclough, 1999). As such, during the reading of the texts (the focus group transcriptions), I highlighted specific textual elements (the discourses) that represented a reality as understood by the participants of the focus groups. The focus is on the discourses that were related to the problems I identified in the first step of this CDA (a lack of shared understanding of empowerment and the practice related to this understanding).

Table 3 illustrates the two central discourses identified within this theme (*empowerment* and *resistance discourses*) and its respective sub-discourses. In what follows, I address each central discourse in turn.

Table 3

The Core Discourses of the Creating Empowerment Theme and its Respective Sub-Discourses

Main discourses	**Sub-discourses**
(1) Empowerment discourse: participants' views of empowerment	– Knowledge base – Working and life experience – Sense of control – Sense of inclusion – Employee status within the organization – Check out health – Feeling on top of things – Appreciation and acknowledgement – Working environment – Role expectation – Hierarchical system – Providing information
(2) Resistance discourse: ideas and beliefs the participants indicated that affect the empowerment process	– Medical power – Universal health care – Canadian culture – Cultural change – Measurement approaches – Questioning the power of the organization

(1) Empowerment discourse: The first central discourse, the *empowerment discourse*, brings together the participants' views of empowerment and some processes

that enable or hinder the empowerment process within the organization from the participants' perspectives. I identified twelve perspectives of empowerment within the focus groups, which are represented by the sub-discourses. For example, according to a staff member, empowerment is "constantly dynamic" and "it's not somebody else, it's each of us, within us"; therefore, the organization should foster empowerment by building a "knowledge base" in which the future generations of members can "learn" from the "empowering experience" of the others. Note that this participant implies that knowledge is somewhat individual and a role of the organization is to construct a base in which others can incorporate that knowledge. This *knowledge base discourse* also suggests a continuation, a preservation of the experience of previous generations for the future ones.

Some participants elaborated that their learning process about empowerment was built around their life and working experiences. A staff member highlighted "I was a popular educator before. (...) I traveled in ((overseas)) (.) for six months and I think that changed my worldview". This participant went on to say that those working and life experiences made empowerment becomes "embedded in my belief system; (...) the ((empowerment)) values become immersed". Another staff member also narrated an experience overseas, when the participant was "involved with theology of liberation". Also, the team this individual participated "were in contact with small group, grassroots groups" and the objectives of the programs was "to re-read the bible and see how it connects to their reality". Most importantly, this staff member claimed that "it was a program of empowerment, actually". A third staff member mentioned a relation between empowerment and working experiences in other settings: "I always had (.) managers or directors who I just modeled after, who they knew they were client-centered, they knew what they want to do. (...) I just kept finding my way to do that as

a manager". Also, the same participant expressed that relationships with clients and partners add to the organization's "expertise" in health promotion. The *working and life experience discourse* along with the *knowledge base discourse* demonstrated that the participants' notion of empowerment came from a practical knowledge; therefore, experiences and relationships with people and colleagues seem to have more impact on their understanding of empowerment than books, articles, or other formal repositories of knowledge.

Another staff member understands empowerment as a "sense of control that one feels or has over parts of their life and hopefully all of their lives"; therefore, for this participant, organizational empowerment is a "sense of control within the workplace". Note that this participant has used the verbs *to feel* and *to have* to talk about empowerment which might imply that empowerment is both a sentiment and a possession and can be both concrete and abstract. Two additional participants (one board member and one staff member) articulated that their understanding of empowerment relates with a sense of control. The board member explained that empowerment is a "process" where the objective is to "create the conditions where communities or individuals or (.) countries are in control of their resources for themselves". This board member relies on the concrete verb *to be* to describe empowerment. In addition, this board member has introduced this statement with "empowerment needs to (.) in an ideal world (.) take control of the issue"; this implies that, for this participant, a concrete "control over" might happen only in an "ideal world". The second staff member who used *control over* had a different conceptualization because this participant admitted less familiarity with the concept of empowerment. As a result, although only a minority of the participants of both focus

groups mentioned the expression *control over*, this discourse has divergent articulation among the participants of the focus groups.

A sense of inclusion was also underscored by three staff members as an empowering characteristic of the studied organization. One participant articulated that "I felt (.) very included" when that individual begun to work in the organization and this sense of inclusion adds to the "empowerment culture". This participant also generalized this sense to the others' staff members by stating that the organization is "empowering for all us that work in so many different capacities". In addition, this individual also made the point that the organization has a "welcoming environment" that encourages people to become a "welcomer", a person who will also "include" the others. Two staff members told their experience in other organizations, where they felt their boss was not confident in their work and that made them feel detached from the working process and, consequently, disempowered. They also contrasted that past situation with their current feelings of being cared by the other members and, consequently, confident about the work they are doing at the present. As a result, I can imply that the participants consider a sense of inclusion as an empowering characteristic of the organization.

Contrasting with the *sense of inclusion discourse*, which implied a sense that the organization includes all the people who work there, a staff member articulated that "I previously happen to be here for a while by having contracts" and this was "a factor" that impacted this individual's empowerment perception of that time. This person acknowledged that when one has a temporary contract, "the space of the department is different" because "you're only here for a while". Other staff members agreed with this individual by saying, "more and more we're all here in contract (...) it's important about how you are attached here because it's not always been equitable". Through these comments, the participants suggested that the staff members under casual contracts may

have a different relationship with the others and, consequently, might have a reduced feeling of empowerment.

A different perspective on empowerment was given by a staff member, who linked physical health with empowerment:

> we maybe have to check out our health, because I think there are other things that have occurred, are occurring over the year that we haven't always been so (.) maybe as a group of healthy but (.) we've been fatigue, we've been stressed (...) We've been going to chiropractic, physiotherapy, the nurse.

It is important to note that this participant made a link between heavy workload and poor physical health; the poor health, in turn, minimizes their sense of empowerment. Some participants provided a similar perspective on the impact of workload in the empowerment sense. One staff member argued that "I'm not feeling really empowered cause I'm just (.) really fatigued from everything (...) I just feel defeated". Another staff member used the expression "to feel on top of things" to describe that when the workload "is too much", it affects "the empowerment feeling". In these two last examples, the staff members suggested a direct link between heavy workload and empowerment, without mentioning *health*. It means that, for these participants, when people are "drowning in work", it becomes difficult to feel empowered because of the workload per se, and not because the health consequences of the workload. In the end, however, the staff members acknowledged the detrimental dimension of the heavy workload to their health and empowerment perceptions.

Some participants had different perspectives on the impact of the heavy workload on the sense of empowerment. Two staff members valued the "appreciation and acknowledgement" of the organization's members in respect to their work; the appreciation and acknowledgement for the participants is "empowering" because it

surpasses the pressures of the heavy workload. Another staff member went further to say that the workload "depends on what the kind of work you do (.) sometimes is challenging what you do and you feel more empowered". Note that this last participant explicitly said that workload can be empowering in some situations. A third staff member elaborated that what "is empowering ((in the organization)) within that ((heavy workload)) context is that, unlike other places that I've worked, I don't for a second hesitate to think that I can let people know ((that I can't do a specific task because of the workload))". For these staff members, the organization is empowering when it acknowledges and appreciates the work of the employees and enables a flexible working environment in which they can feel confident about their work, even though the workload is heavy.

For the staff members, the working environment and their relationships with colleagues were also deemed to be empowering and expressed this using the word *culture*. Many staff members elaborated that the organization is "very different" from the other places they worked and that either the allowance to "wear the jeans" or talking to your "boss" with a same position of importance are empowering characteristics of the organization. One staff member articulated this idea by arguing,

> my understanding of information flow is that (…) you lose information when you have people who are not equal sort of *footing* (…) to me ((organization)) it's empowering (.) because we <u>somehow</u> feel (.) seem to manage to find a place where we can escape *that kind of what I call non-sense*.

This participant described as *non-sense* the top-down approaches of other organizations. Another staff member exemplifies the environment of the organization by narrating "a period of time" that this person "didn't enjoy" the work; but, "what kept me here wasn't <u>what</u> I was doing, but it was the people and that sense of being <u>valued and supportive</u>

that I just, quite frankly, in that time I couldn't have imagine in many other locations". The same participant gave another example of the working environment of the organization:

> I sit regularly around the table with three other non-profits and even (.) just the language that they use is not language that (.) would (.) work well within this environment. So, you know, a small little example. A ((position within the organization)) will talk about how she's gonna "voluntold" her staff to do something. Well (.) I would just say "I'm going to ask them!" (…) And I just find it actually very staggering because it creates a whole different environment to be told you're volunteered to do something versus (.) asking.

From these excerpts, one can observe that these participants view the organization as enabling empowerment by fostering a caring and supportive environment.

According to another participant, even the arrangement of the office was connected with empowering experiences. A staff member argued that the arrangement of the office makes this individual "hear ((colleague's)) conversations with clients, partners, connectors, other people outside the organization". This fact is not "negative" because "the voices are those of a (.) supportive (.) exchange, helping to build relationships. (…) I just, just sort of hearing now, but I'm gonna to be at the phone and doing the same thing". Another staff member suggested that organization's empowering environment makes a difference in the way the staff members deal with the clients and partners. As this participant explained, "feeling empowered as I do ((as)) a service provider, than helps us ((to)) insure that the clients (…) also feels that". On other occasion, this same participant also said that the way they deal with the client has also to do with "energies":

> there's energies in this world that we don't see it. We can almost feel it. People used to say they could walk into our offices and just feel something. (...) *I don't think they necessarily say we've feel empowered* but you bring something different with the table, or the room, or the something.

The way this participant described this "energy" seems almost transcendental, something that is a foreign idea at the organization. This quotation exemplifies that not only the working environment is good for the staff members' perception of empowerment and their relationship among them, but also it makes people change their relationships with other people outside the organization. The *environment discourse* embraces a notion of continuation, in which the staff members reproduce the attitudes of the others members. Furthermore, this discourse resonates with the *knowledge base discourse*, which entails a sort of continuation of knowledge and attitudes.

In terms of the vocabulary the participants used in the *environment discourse*, I identified that the terms used to qualify the organization were *empowering*, *supportive*, and *different*; conversely, other organizations are *non-sense*, *top-down*, *traditional*, and *inefficient*. The contrasts of these adjectives are interesting because they demonstrate the difference of the participants' feelings about these environments.

Another point linked to the *environment discourse* was made by a staff member, who suggested that the "background and context" that the employees "bring when they come ((to the organization))" also influences the working environment. For this participant, Canada is an "individualistic society"; this staff member went on to add that there are "other societies, which are not so individualistic", societies where the individuals "have expectations, role expectations and than you have different role expectations in a Canadian workplace". This participant made clear that the idea of Canadian individualism results in different role expectations and different relationships

with colleagues, but the participant did not go further to explicate other implications of this individualism. This staff member also criticized the role expectation of other cultures by narrating a story of a person from another country who asked "Can you fix me up the job in your organization?" The others' reactions to this comment demonstrated that this kind of attitude is unacceptable in the Canadian workplace. As a result, while the Canadian culture was deemed individualistic without further considerations, the "fix me up a job" story triggered a discussion about hierarchies and privileges within the workplace.

All the participants of the staff members' focus group agreed that the horizontal relationship between the managers and the other staff members that exists in the organization is empowering. Two staff members articulated that "the situation of being able to, you know (.) talk to your ((boss)) with the same ((level of importance))" is empowering. This participant went on to add that the fact "the hierarchies are definitely there ((in the other work))" is disempowering because "it's a power over versus a power with situation"; other participant concurred with this idea by saying that "I think sometimes most organizations still build on kind of a parental model that (.) someone up there *will tell us what to do*". It is interesting to note that these participants described the other organizations as a *power over* situation. In contrast, the studied organization enables a *power with* environment, which underlined a shared power relation among the staff members.

Another staff member demonstrated a different view of the role of hierarchies that has to do with cultural sensitivity. This individual said that "You may come from places where, you know, have hierarchal systems of what you are used to and <u>therefore</u> you feel more comfortable in a place where you know exactly what you are supposed to do". Another participant concurred with this idea saying, "<u>Hierarchies aren't bad</u> (...) to feel

that you know what the structure is and that you go to someone and so on could be quite empowering for someone (...) this is where that power over shifts". Thus, for these participants, power over processes might be empowering because they depend on both people's cultural background and the way that the power flows within the organization. It is important to highlight that other participant resisted to this idea by arguing that it is "sort of pessimistic view of human nature to say that all the people just need to be told what to do". It should be noted that this participant has rejected the hierarchies as a top-down approach on the basis of human nature; on the other hand, the other participants highlighted that hierarchies are a cultural matter. Thus, there was some sort of tension between the participants regarding the role of the culture and autonomy within the workplace.

I suggest that there were three perspectives on the *hierarchy discourse*: (a) some highlighted the matter of power among the staff members in a neutral way, assuming that this situation is good in any sense; (b) others articulated that hierarchies are relative to the people's cultural background, assuming that in some situations a top down approach may be empowering; (c) some advocated that autonomy is part of the human nature, assuming that power over situations are somewhat detrimental for the environment. This *hierarchical discourse* represents the major tension among staff members since it embraces different views of the impact of hierarchal systems in the flow of power within the organization. In what follows, I shift the focus from the staff members' conceptualization of empowerment to the board members' views on this matter.

Contrary to the staff members, members of the board of directors depicted empowerment as providing information on health promotion issues: "To me, empowerment is really about giving (.) helping to provide information". Another board

member went further to say that "I think sometimes I don't know if I could interchange these two terms ((empowerment and giving information)) but it feels like almost I could". I divide the aspects of discourse discussed by the board members into the four sections: (a) the way the organization provides information; (b) the audience of this information; (c) the kind of information provided; and (d) the expected outcome of this process.

In respect to the way of providing information, the participants articulated that the organization's role is "helping to provide information" by providing "resources, tools (...) consultations, and facilitation and actual face-to-face contact" and "a lot of courses". It is interesting to note that one participant was emphatic to say that the organization's role is to disseminate information and not necessarily produce new knowledge: "The main challenge is to make sure that people know what is available for them (.) I don't think it's the volume (...) it's just to (.) let the communities know".

For the participants, the audience of this information is diverse: individuals, population, communities, neighborhoods, organizations, professionals, and health intermediaries; in addition, the audience can be "large or small, or global or very local". The participants agreed that the organization "has to make the biggest impact. And the biggest impact I think is most upstream you can get to affect (...) the most number of people". Endorsing this statement, one board member pointed out,

> I don't see it as illegitimate to look at empowerment of an individual. I mean, sometimes that's important to do. ((organization)) I think (.) takes a broader view than empowering individuals and provides resources to (.) professionals who can (.) I'm hesitating to use the word help because that's a bit patronizing. But it is (.) it's to enable, shall we say, communities.

In respect to language, this participant made a distinction between the verbs *to enable* and *to help*. After this comment, the board members acknowledged that there is an important difference between these two terms:

> There's nothing wrong with helping but help can embody (.) a tradition that's patronizing. It might focus on weakness rather than strengths. And if we want to empower we have to focus on strengths and enabling seems to capture the idea that we focus on ability rather than (.) gaps in people or communities.

Thus, for this participant, when one is helping the other, this means that the other is weaker than the one who is helping. Thus, because the word *enabling* seems to not imply a weaker position of the other, this participant prefers to use this word. Before this comment, some board members were using the word *help*; after, all the board members avoided using this word. Ultimately, the board members recognized the importance of the language in their relationships with the clients.

The third feature of this discourse is the topic of the type of information. While some board members talk about health promotion in general ("here we are talking about health, specifically, health promotion"), other participant gave more details: "specific medical health issues that people are concerned about, (…) mental ((health)) and political issues, (…) social justice, ((also)) global economic issue that (.) are important and are captured with the word empowerment". This same board member also claimed that "if we want to empower we have to focus on strengths (…) rather than (.) gaps in people or communities". As a result, for the board members, when one is working within an empowerment approach, the issues that can be addressed may be very specific or very broad, but health promoters should focus on "strengths" of the population, rather than on weaknesses.

Finally, the outcomes of the empowering process of providing information were articulated in diverse ways. For a board member, the outcome of empowerment is to "change a situation (...) empowering somebody to move forward". This participant went on to say that "empowerment is all about assisting a community or a population or a group of people or even an individual to (...) be responsible for their good health". Another participant articulated that "The organization (...) does look at influencing policy changes. (...) So, that's the way it ((organization)) has to operate (.) at a very upstream level". Going on with this discussion, another board member argued that "we can't do it ((influence policy change)) by ourselves. That partnership is really essential here". In articulating how the organization can influence public policy, a board member said

> we somehow have to set the tone and have to lead and show (...) why politicians should care about health promotion (...) I think that's why ((organization)) needs to continue lobbying in that regards to make sure that one day somebody will listen and change (.) and make some significant changes to the system.

Replying to this last point, another board member pointed out that "there's an issue in (.) hoping that it would be noticed health promotion is working because (...) we don't have the measurement that medicine does, and, you know (.) I don't think that we will be noticed". Thus, the board members placed a lot of effort in considering social and policy changes as important outcomes of the organization's activities, but recognized the difficulties in making the political system more involved in health promotion activities. In sum, the *providing information discourse* represents the main way the board members conceptualized empowerment. Various aspects of this discourse were addressed by the participants, but as a whole, the board members agreed that empowerment at a "upstream level" is the direction the organization should work, while

acknowledging that focusing on individual or specific diseases is also important for empowerment strategies. In what follows, I address the second main discourse – the *resistance discourse.*

(2) Resistance discourse: The second main discourse – the *resistance discourse* – is in line with the analysis of the conjuncture, in which the participants criticized the current medical approach to health promotion and the political system that supports this approach. The expression *resistance discourse* came from my impression that the participants, in general, resisted the traditional ways of promoting health and the organization of the health system, although no participant in reality adopted this expression.

The first focus of resistance was to the power of the medical community in the health promotion. A board member said that the health system places much more emphasis on "the doctors". This participant also suggested that the doctors have power over the "politicians" and the population by arguing that "Every time there's anything like a doctors' strike? They got twenty thousand people talking to the population front line and it's just (.) keeping people engaged in the medical model". Concurring with this statement, another board member articulated, "They ((medical community)) influence politicians. Politicians won't take on the doctors".

Two board members also attributed responsibility on the universal health care system for fostering the medical model in the general population. One participant declared that "for the most part we don't pay for it (...) you look at societies where every time you go to a doctor you have to pay (...) there is more an incentive on you to stay healthy and be healthy". Other board member suggested, "the system is just getting better, more accessible, less wait time. Why ((would)) we change it?"

The board members agreed that the health promotion emphasis on the medical approach is related to the Canadian culture. One participant said that the medical model is "just a reflection of our society, of how (.) *I hate to say it* but how lazy we've become and how we just want instant gratification and instant results, for instance". Another participant endorsed this opinion by saying that "as a culture Canadians are not very critical. (...) We see ourselves as polite but part of that polite (.) it's their laziness around and conservatism, around politics and political philosophy and that extends to other things". This board member went on to say that working toward health promotion would impact the cost of living and the population "doesn't want to do that". Thus, it seems reasonable to conclude that the board members asserted that the Canadian culture may prevent people from engaging in health promoting activities and it even might help to perpetuate the medical culture of the health system.

Contrasting with this opinion that the medical model influences the politicians and people's behaviors (and consequently impacts the health promotion practices), the board members rejected the idea that the organization should work toward changing this culture. When questioned about the role of the organization in changing this culture, a board member responded that cultural change "may be a consequence of ((organization)) work, but they've got enough on their plates right now (...). And now I wouldn't want to say, 'ok, on top of everything else you do, get out there and change the culture'". Another participant replied that cultural change may occur since "we do what we can, where we can, but I don't ever see it being a core strategic direction or core piece of work that we do".

Another point of resistance elaborated by the participants of both focus groups was the current evaluation methods of health promotion interventions. For the majority of the participants, the measurement system adopted by the "politicians" and "funders"

is not consistent with their way to perform health promotion programs. A board member argued that the current measurement approaches to health promotion are more linked to the medical model:

> We ((organization)) don't have the measurement that medicine does, and, you know (.) I don't think that we will be notice. That's why we are in our ((year)) anniversary without much profile. And because health promotion is a sort of background, work reporting people to take control of their health and their life, there's not a lot of profile in it.

Other board members confirmed that, "it's hard to provide any influence when we can't show the evidence", and elaborated that the politicians "look at communication, how many anti-smoking campaigns do you have (...) How many brochures do you have given out? How many website hits have you got? Like (.) they're very narrow in what they are looking for".

The staff members also noted the difficulties in measuring the success of health promotion and empowerment programs. A staff member recognized that "it's an issue" to "balance the funders' needs with our own needs", because "what they ((funders)) want us to *measuring, count* it's not always what we want to measure, count". This participant went on to suggest that the organization "don't even now know (...) what we want to do either or we feel important, but I know that there's been effort in trying to capture the stories". Another participant acknowledged "nobody does evaluate it ((health promotion)) beyond the process. Do they ((funders)) like it? (...) Yes, *they like it* but that doesn't tell us it is a good (.) good, better, best practice". A third staff member suggested that "we could do one workshop and it might have much more of an impact than doing twenty. But, it does look better ((for the funders)) to say that we've done twenty so we do all of those". In addition, this same participant recognized that

"what we're measuring is very different than change in a community". This implies that even though the organization does "twenty workshops" and "people enjoy these workshops", this participant acknowledged that the content of these workshops may be not translated into community change. Another staff member talked about the "reporting forms" that the organization is "required to use to our primary funders". This participant said that, in those reports, the organization tries to

> build in a story. (...) you got a number there, but ((we are)) talking about the impact, the difference (...) whereas other organizations have similar report requirements, they just gave the numbers. They say the ((funder)) doesn't ask for anything else, they don't read it! It doesn't matter! Give to them! They might ((read)) some day, right? (.) But it was just a completely different perspective.

This participant made the point that even though the organization is aware of the limitations of the funders' reporting forms, the organization insists in adopting (or at least combining with) a way of measuring the interventions which is in line with its ideals. Note that many participants criticized the approach of the funders and politicians to the health promotion measurement, but they also acknowledged that they have to abide by funders' decisions.

The last sub-discourse under the scope of the *resistance discourse* was identified in the comments of one staff and one board member. These two participants were the unique voices in their focus group to question the power of the organization to enable empowerment within its own environment and also within the social environment. The staff member questioned the capacity of the organization in hearing people that "didn't feel so empowered". In response to this comment, another staff member suggested that it "can happen ((that)) people are coming to this environment and not feeling empowered. (...) maybe there's another place for them where they would be

empowered". It is interesting to note that this participant claimed that there has to be a "fit" between the employee and the environment in order for the relationship between organization and employees become empowering. This quotation also implies that it is the responsibility of the employee to "fit" to the environment, not the opposite. Both staff and board members have also questioned "how empowered we are as an organization, so that we actually have influence out there". A board member said, "I have a bit of a dilemma" with the organization being empowered to enable other groups. This participant added that because of the "funding mandate" the organization cannot "do a revolution and lose all (...) funding". It was interesting to note that these staff and board members' provocations were not confirmed or refuted by the others participants.

Summary of the discourses of the creating empowerment theme. The focus of the creating empowerment theme was the participants' understanding of empowerment and ideas and beliefs they shared which had an influence on the empowerment processes. As demonstrated above, the board and staff members depicted different notions of empowerment, but they generally agreed in the beliefs and ideas that influence empowerment processes.

At this point, it is possible to locate the discourses within its order(s) of discourse mentioned in the analysis of the conjuncture. For example, in terms of health promotion approaches, the whole set of *resistance discourse* emphasizes political and social processes of health promotion, which can be related to the socio-ecological approach to health promotion. In contrast, the majority of the sub-discourses set of the *empowerment discourse* seems to belong to the behavioral approach because the sub-discourses concentrate on working attitudes among the staff members. Table 4 summarizes the sub-discourses and its respective order of discourses from a health promotion perspective. It should be noted that some sub-discourses are located in more

than one order of discourse because of their different nuances. It is important to underscore that the majority of the sub-discourses are located within the behavioral approach to health promotion, demonstrating that the participants focused on personal attitudes when discussing about their understandings of empowerment and the ideas and beliefs that influence empowerment processes. Also, the sub-discourses focused on the behavioral approaches were also identified in the staff members' discourses. In contrast, the majority of the board members' discourses embraced a socio-ecological perspective. Also salient is the fact that few sub-discourses were identified in the medical approach to health promotion and the intraorganizational dimension of empowerment. This means that the participants of the focus groups did not emphasize disease prevention approaches as empowerment strategies. Furthermore, they did not mention the link between organizations as an empowerment process.

Table 4

Orders of Discourses of the Creating Empowerment Theme: Health promotion Approaches

Order of discourse / **Sub-discourses**	**Medical approach**	**Behavioral approach**	**Socio-ecological approach**
Knowledge base		✓	
Sense of control		✓	
Sense of inclusion		✓	
Employee status		✓	
Working and life experiences		✓	
Check out health	✓		
Feeling on top of things		✓	
Appreciation and acknowledgement		✓	
Working environment		✓	
Role expectation		✓	✓
Hierarchy		✓	✓
Providing information	✓	✓	✓
Medical power			✓
Universal health care		✓	✓
Canadian culture			✓
Cultural change			✓
Measurement approach		✓	✓
Questioning the power of the organization		✓	✓

In terms of the orders of discourses from an organizational empowerment perspective, the staff members' discourses (e.g., *knowledge base*, *working environment*, and *life and working experience*) can be related to the intraorganizational OE order of discourse because they are concerned to internal processes of empowerment. On the other hand, the *providing information discourse* identified in the board members' focus group belongs to inter and extraorganizational dimensions because it emphasizes dissemination of information, which, according to Peterson and Zimmerman (2004), is an extraorganizational process of OE and promotes interaction between organizations and communities, which is an interorganizational process. Table 5 presents the sub-discourses identified in the focus groups and its respective order of discourse. Again, the sub-discourses can be located to more than one order of discourse because they embrace various processes.

Table 5

Orders of Discourses of the Creating Empowerment Theme: OE Processes

Order of discourse / **Sub-discourses**	**Intra-organizational processes**	**Inter-organizational processes**	**Extra-organizational processes**
Knowledge base	✓		
Sense of control	✓		
Sense of inclusion	✓		
Employee status	✓		
Working and life experiences	✓		
Check out health	✓		
Feeling on top of things	✓		
Appreciation and acknowledgement	✓		
Working environment	✓		
Role expectation	✓		
Hierarchy	✓		
Providing information		✓	✓
Medical power			✓
Universal health care			✓
Canadian culture			✓
Cultural change			✓
Measurement approach		✓	✓
Questioning the power	✓		✓

In what follows, I present the discourse of the second theme of the focus groups, *engaging in what is important.*

Discourse of the engaging in what is important theme. In this theme, I present the participants' ideas on how the organization puts in practice what they think is important for the organization. I identified three main discourses: (1) *Collective ownership*; (2) *Managerial*; and (3) *Resilience.* In what follows, I detail these discourses.

(1) Collective ownership: During the staff members' focus group, there was a general agreement that the organization enables empowerment by fostering a *collective ownership* of the working process. For a participant, it is important that "we all feel like there is a collective (.) ownership (.) that's what we can manage". Another staff member agreed that "we're team players (...) and there are always meetings that we focus on the same thing together". One staff member narrated a situation where the organization was facing a "tumultuous time" where the staff members were organized in "transition groups that helped pay attention to what was happening internally (...) so, it also did say that somewhere we were enough together ((to face that situation))". Another staff member mentioned that "It's not just us as individuals, but we enjoy working with each other, which really adds to the sense of (...) empowerment". Through this discourse, it becomes clear that the organization enables empowerment to its staff members by promoting a collective ownership of the working process.

(2) Managerial discourse: For the staff members, the way the managers relate to the other staff affects the empowering processes within the organization. A participant was emphatic about the importance of the management to the working environment by claiming that the culture "depends of the management, what kind of management is there". Another participant described a situation where the team "experienced no management"; for this participant, the team was trying to "establish a different form" of

leadership, but it did not work because they were "paralyzed", they "couldn't work well". In that moment, they "had to choose a manager in order to survive". Another participant elaborated on this matter by saying that,

> we didn't want to be managed or suddenly out of a group of colleagues now have someone to say "I'm the manager." So, it was much more a shared team leadership that we were trying for. However, we wouldn't have, had voice around the table without somebody being designated as that. So, that meant that somewhere in part of the culture something was shifting to say at that point that somebody has to be designated ((to be a manager)).

A third participant articulated that "we did play a part in creating something that was different. It did come from the early founder who himself was often perceived as not being empowering, but in fact had a different mental model about how you create capacity". This participant went on to add that the way this founder worked "had a *downside*; people coming expecting to have some parameters and some structure, were lost for a while. So, that's not empowering". Although the action of the manager was deemed empowering for some people, others might have experienced it differently. However, all these comments demonstrated the centrality of the manager in the working environment and empowerment processes.

(3) Resilience discourse: In this discourse, the staff members emphasized their ability to become stronger after a difficult situation and many staff members have declared they consider themselves resilient. A participant articulated that empowerment may be "permanent because it is part of what (.) who you become and you have that resilience, that resiliency that you depend to". This participant said, "your spirit can't be broken. You can't lose it". A second participant narrated a situation where the organization was facing "tumultuous times". The participant said that,

> I think some of us have asked ourselves how we stay resilient through that ((tumultuous times)). So, that's, you know (.) something to ask, I have no idea yet. Except that the more you go through it maybe the more you can kind of go and "ok, we're sinking again, what would we do?"

For this participant, the experience was important to construct the resilience of the organization's members. Further, this same participant not only re-stated the resilience of the organization' members, but also related resilience with empowerment:

> there's always a shadow side to understand that to be (...) resilient (.) there are challenges, and there are dark times there. So that everyone isn't always happy, happy, happy, cause empowerment isn't. I don't think is about being happy, happy, happy, but *it's about being able to ride what's coming out us in some ways*.

Thus, empowerment and resilience are connected in the sense that the participants can develop an ability to go through a difficult situation and remain confident about their future.

Summary of the discourses of the engaging in what is important theme. For the participants of the staff focus group, collective ownership over the working processes, managers, and resilience are important practices performed by the organization's members that enhance their empowerment experience. Also, those discourses represent how the organization helps to build an empowering, protective relationship among the people in the organization.

The discourses identified in this analysis are mainly located in two orders of discourse: (a) behavioral approach to health promotion, and (b) intraorganizational OE processes. I identified the *collective ownership*, *managerial*, and *resilience discourses* in the behavioral order of discourse because the participants elaborated on attitudes that

improve their working processes and increase their experience of empowerment. Since the participants focused on internal processes of empowerment, the intraorganizational dimension of OE seems to be a good fit.

Focus groups' voices. According to Chouliaraki and Fairclough (1999), the voice analysis aims to examine from which identity the individuals represent themselves in social events (e.g., conversations, personal communications, and reports). Fairclough (2003a) explained that "Who you are is partly a matter of how you speak, how you write, as well as a matter of embodiment – how you look, how you hold yourself, how you move, and so forth" (p. 159). Further, "messages about both social identity (e.g., social class) and personality are carried by the variable selections people make from words" (p. 162). In other words, the language individuals utilize translates their social identity into the social world. Voices are also concerned with the image of people, or organizations desire to project for the social world (Chouliaraki & Fairclough, 1999). Thus, to examine the texts' voices is to analyze the identity the participants projected during the focus group interviews.

From this perspective, four voices were identified: (a) expert; (b) ordinary life; (c) supportive; and (d) pessimistic. The *expert* and *ordinary life voices* were identified in both staff and board members focus group. The *supportive voice* was identified only in the staff member group, while the *pessimistic voice* was pinpointed only in the board members' focus group. I first present the voices identified in the both groups and then present the voices unique of each group.

(1) Expert voice: In both focus groups, the participants represented themselves as experts in health promotion, empowerment, and politics. When a staff member declared that has been working a "long time as health promotion consultant", or when the board members suggested that to give information is empowering, it implies that the

participants are experienced and have expertise in the health promotion field. More importantly, at the moment that the organization offers "a lot of courses" that "empower the population", according to the board members, the organization makes explicit its expertise over the clients.

(2) Ordinary life voice: This voice represents the fact that the participants articulated their thoughts using everyday expressions, such as "They ((the politicians)) go for the dollars", "We're all hanging on together", and "Some organizations do that kind of stuff, you know". These ordinary language expressions make the interaction more informal.

An additional voice related to the *ordinary life voice* is the *emotional voice* identified in the staff focus group. In some of participants' statements, I identified the existence of an emotional connection among them (e.g., "those were devastating times quite frankly (...) I would say there was (.) almost an emotional void"). Also, the fact that some staff members valued the personal connection among the organization's members ("when you work with somebody it's really good to know them") also means that emotions are part of the empowering relationships in the working environment.

(3) Supportive voice: Throughout the staff focus group, the participants expressed their thoughts in a collective way, generalizing their comments to all members of the organization. As a result, this group of people shares many commonalities. The board member participants were also supportive of one another's comments, but in a different way in comparison to the staff members. While the staff members generalized their thoughts by, for instance, using the pronoun *we*, the board members explicitly stated they agreed with the previous comments. It seems that the staff members are comfortable in generalizing their comments to the others participants, while the board members avoided doing so.

(4) Pessimistic voice: This voice was identified within the board members' focus group. Some board members demonstrated a pessimistic view about changes on the health promotion structure, or a society's cultural trait when they said that "It's hard to change those things", "Politicians won't take on the doctors", and "If you're not (.) you don't have to pay to go to the doctor than why you should be responsible for your own health?" Implicit within these statements is a pessimistic idea that both political and social systems are very difficult to change. This *pessimistic voice* was not identified within the staff members' focus group, although the participants discussed the challenges they face around, for example, the financial structure of the organization. This aspect is important to note in light of the *resilience discourse* identified in the staff members' focus group. It seems that, because the staff members are resilient to face the challenges, they see the future more positively.

Summary of the focus groups' voices. Focus group participants represented themselves in various manners. Both staff and board members represented themselves as experts in the health promotion field; they also relied on everyday language to express themselves. However, the *supportive voice* was exclusive to the staff group while the *pessimistic voice* was exclusive of the board members group.

Analysis of the discourses: Annual reports. This section presents the analysis of the annual reports following the same CDA framework adopted in the focus groups. I analyzed nine organization's annual reports (from 2001 to 2011). Figure 5 outlines the theme, genres, discourses, and voices I identified in those documents.

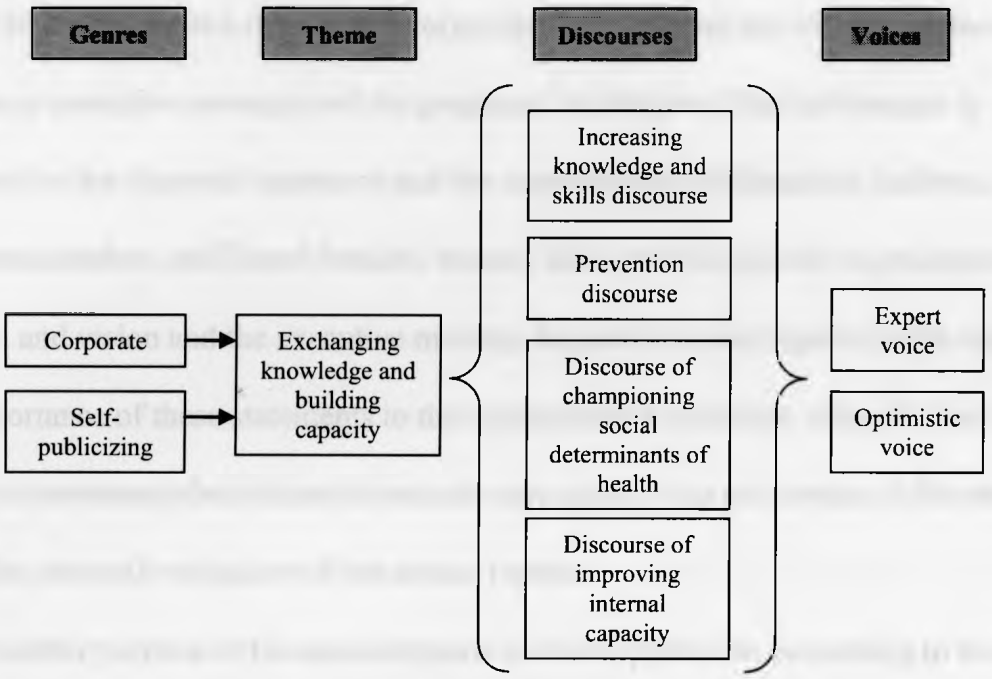

Figure 5. Genres, discourses, and voices identified in the annual reports.

In this section I first present the genres, followed by the theme, discourses, and voices.

Annual reports' genres. The annual reports entailed several genres. Table 6 summarizes the genres identified.

Table 6

Summary of the Annual Reports' Genres

Activity	Social Relation	Communication technology
– Corporate – Self-publicizing	– Experienced status – Partner status – Narrative style – Visual imagery – Self-advertizing	– One-way mediated interaction

Corporate is the genre that represents the main activity of the annual reports. According to a personal communication with an organization's member, the primary purpose of the annual reports is to release its financial statements[15]; but, the reports also include information about significant events during the year. I believe that the annual reports are a form of resistance, because something that is imposed by the funders is transformed in something that is valuable for the organization.

[15] According to the organization's member with whom I communicated, the publication of the financial statements is required by Canadian law.

The annual reports included the organization's mission and vision statements as well as an executive message and the programs' highlights. This information is followed by the financial statement and the organization's information (address, telephone number, staff's and funders' name). Thus, the fact that the organization's mission and vision and the executive message begin the annual reports might represent the importance of these statements to the organization's activities. Also, the fact that the financial statement often closes the reports may signify that the release of this statement is not the primarily objective of the annual reports.

Another purpose of the annual reports is to self-publicize. According to the same personal communication referred above, the organization's members use the annual reports as a "promotional tool" that they "hand out when meeting key individuals". It is clear that the annual reports serve to publicize the image of the organization by raising support both monetary (e.g., financial assistance for a project) and non-monetary (e.g., credibility and confidence from clients and funders). This self-publicizing purpose also supports the idea that the primary purpose of the annual reports may not be the release of the organization's financial statement.

The annual reports are informative in respect to the description of the yearly projects. Details about the project include: the name of the project, the target population, the deliverables, and, less often, the outcomes and funders of the projects. They also provide quantitative data by displaying, for example, the numbers of clients served, or topic addressed by the services. Thus, the annual reports combine qualitative and quantitative information about the organization's activities and, thus, enhancing their credibility with clients, partners, and funders.

I identified a progression of the reports' design from simple to more complex layouts over the nine years of reports. In all reports, the majority of the messages are

delivered in form of written text. However, from 2006 to 2010, the organization used an increasing number of visual aids to communicate its messages. In early years (e.g., 2001 to 2003), the reports were black and white with few pictures and no charts. Over the years the reports became more colorful and with considerably more images (e.g., pictures, charts, and tables). The description of quantitative information, such as the number of consultations, training, and events was, in early reports, integrated into the texts. In more recent reports (from 2006 onwards), charts and tables are used to display those numbers, meaning that the maybe organization values the presentation of the quantitative information. There were pictures of the organization's members[16] in early years, but this practice was abandoned in more recent reports. In contrast, the use of general pictures[17] grew. Thus, it seems that the organization moved from a more personal approach to the annual reports to a more corporate view. However, the organization maintains a personal approach to the annual reports' design when it displays clients' and partners' comments in praise of the organization's services. Some praises are constituted by words of gratitude and incentive, the impact of the organization's collaboration on the client's works, and the importance of the organization for the health promotion field. These personalized comments can also be considered a self-publicizing strategy. See Table 7 for a summary of the design features of the annual reports.

With respect to the social relations, the annual reports are, according to a personal communication with the organization's member, produced for a wider audience: clients, partners, collaborators, funders, and potential funders. It was beyond the scope of this study to gather data on the social relationships established to produce and consume the annual reports; as such, all the data gathered for this section was gathered through

[16] Generally, the pictures portrayed the members in meetings, presentations, or casual pictures took in the organization's facility.

[17] General pictures include images of people (representing the clients), landscapes, and organization's resources.

extensive reading of the annual reports and some personal communication with organization's members. In the annual reports, the organization positions itself as both experienced and knowledgeable in the health promotion field. For instance, the majority of the annual reports present a wealth of information about the longevity of the organization, the number of programs and clients served, and the great experience of its staff. As a result, the social relations between the organization and clients seem to be specialist – non-specialist, respectively. In contrast, the use of the words *partners* and *collaborators* when referring to other organizations and funders denotes a more egalitarian relationship with external others. As a result, the organization seems to play multiple roles within the health promotion field, both as specialist (i.e., transferring knowledge for its clients) and partner (i.e., sharing knowledge with collaborators and funders).

Table 7

Design Features of the Annual Reports (Years 2001 – 2010)

Year	Colors	Pictures (number)	Organization's pictures	Charts and/or tables	Client's praise
2001/2002	Black and white	✓ (11)	✓	×	✓
2002/2003	Black and white	✓ (9)	✓	×	✓
2003/2004	Black and white	✓ (8)	✓	×	✓
2004/2005	Colorful	✓ (12)	×	×	×
2005/2006	Colorful	✓ (15)	×	×	×
2006/2007	Colorful	✓ (4)	×	✓	✓
2007/2008	Colorful	✓ (11)	✓	✓	×
2008/2009	Colorful	×	×	✓	✓
2009/2010	Colorful	✓ (20)	×	✓	✓

Note: ✓ - present; × - absent

Turning to the last point of the genre analysis, communication technology, the annual reports are one-way mediated communication because the organization is communicating its messages without a chance of interaction with these consumers of the reports (e.g., clients, partners, and funders). Although the annual reports present praises of organization's clients (which can be seen as an interaction between the

organization and the clients), it is the report writers who choose which praise to present, thus, maintaining the communication in a one-way direction.

Summary of the annual reports' genres. The complexity of the activity, social relations, and communication technology is represented in the annual reports' genres. This complexity can be labeled as *multimodality* – a term adopted by Fairclough (2003a) – that represents the combination of different semiotic modalities (pictures, language) used by organizations to communicate messages with specific purposes and audiences.

Annual reports' themes. Exchanging knowledge and building capacity is the theme identified within the analyzed documents. This theme represents the main organization's activities, which includes providing information to individuals, communities, and organizations, as well as exchanging knowledge with clients and partners about projects that improve "community well-being"; the ultimate goal of these activities is to build "health promotion capacity" to a final purpose to reduce health inequities. It is important to note the provision of information and exchanging knowledge is in line with the specialist and partner status as identified in the genre analysis above.

Annual reports' discourse. Increasing knowledge and skills was a major discourse identified within the annual reports. This discourse relates to the role of the organization in being a "resource centre" by providing "training and consultations", producing "resources for health promotion", building networks, and "advocating for public policy to create conditions that promote health". Through the ways the organization disseminates "health promotion knowledge" by their annual reports, I was able to identify two additional discourses: (a) *resource discourse*, and (b) *collaboration discourse*. With regards to the *resource discourse,* the organization relies on the

production of resources (e.g., brochures, pamphlets, guidelines, toolkits) to communicate its messages. Under the scope of this discourse are also the consultation and trainings the organization offer to its clients. The organization's resources and services are available to the clients in various ways: Internet, telephone, teleconference, in person, brochures, forums, and workshops. Networking is also deemed as a resource to build the capacity of partners and clients. Evidence of *collaboration discourse* was in the annual reports, whereby the organization emphasizes its work in collaboration and partnership with other agencies, communities, and groups.

Two additional discourses were identified within the kind of knowledge the organization spreads: (a) *health prevention discourse*, and (b) *discourse of championing the social determinants of health*. The *health prevention discourse* represents the focus of the organization on prevention activities. Many organization's resources aim to disseminate information about, for instance, child obesity, fetal alcoholic syndrome, mental health, and stroke and chronic diseases. The *discourse of championing the social determinants of health* represents the organization efforts in promoting a socio-ecological view of health promotion by, for example, developing a brochure about how to target the social determinants of health, or giving a workshop on how clients can work toward inclusion and equity. Other programs and projects blend both discourses. One example of this is a project that focuses on the reduction of health disparities of vulnerable population "in the critical areas of healthy eating, physical activity, and mental health".

The significance of these two discourses varies across the years. As shown in Table 8, the *health prevention discourse* is present in all reports, but it has decreased its importance in the last two reports. The *discourse of championing social determinants of*

health is also present in almost all years, but receives much more attention in recent years.

Table 8

Prevalence of Health Prevention, Championing Social Determinants of Health, and Scientific Discourses in the Annual Reports

Year	Health prevention discourse	Discourse of championing SDH	Scientific discourse
2001/2002	✓✓✓	✓	×
2002/2003	✓✓✓	✓✓	×
2003/2004	✓✓✓	✓✓	✓
2004/2005	✓✓✓	✓	✓
2005/2006	✓✓✓	✓	×
2006/2007	✓✓✓	✓✓	✓✓
2007/2008	✓✓✓	✓✓✓	✓✓
2008/2009	✓✓	✓✓✓	✓
2009/2010	✓✓	✓✓✓	✓

Note: ✓✓✓ High prevalence: presence of 10 or more references;
✓✓ Medium prevalence: presence of 5-9 references;
✓ Low prevalence: presence of 1-5 references; × Absent

Table 8 shows the *scientific discourse*, which is related to both *prevention* and *championing the social determinants of health discourses*. The *scientific discourse* represents the efforts of the organization to disseminate knowledge and practices based on scientific evidence. Frequently, the annual reports show that "new evidence" was used to produce brochures and pamphlets, or to give workshops and consultations. The reports also use terms that allude to scientific knowledge, such as *innovation*, *effective/ effectiveness* or *efficient*, or the term *best practices*. The organization's members also perform "literature reviews" and "systematic assessments", which are activities that translate scientific knowledge to organization's practices. The prevalence of the *scientific discourse* has fluctuated over the years (see Table 8), but currently it seems that the utilization of this discourse has been steady and consistent.

The last discourse identified in the annual reports is the *discourse of improving internal capacity*. This discourse is present in the same proportion in all reports and is

related to the organization's efforts to improving internal structures for providing a better service. The reports highlight, for instance, the admission of a new employee, the improvement of an information system, a training opportunity for the staff, or the realization of a strategic planning. The reports also show the results of external evaluations, which the organization adopts as tools to improve its internal capacity. Thus, it seems that the purpose of this information is to increase the credibility of the organization because the organization transmits a sense of interest in improving its services. It also demonstrates the organization's accountability, since the evaluations are utilized to improve its internal capacity.

Summary of the annual reports' discourses. This section presented the discourses identified in the annual reports. From this analysis, I identified that the main activity of the organization is to increase clients' knowledge about health promotion in order to build health promotion capacity (more specifically, health prevention and the social determinants of health). In addition, the organization utilizes a multimedia approach to disseminate its messages.

Although the annual reports did not explicitly define the organization's understanding of empowerment, I can suggest that the organization's practices of empowerment include the dissemination and exchange of knowledge (based on a scientific stance) on health prevention and the social determinants of health. Ultimately, the goal of this empowerment approach is to build the capacity of groups, communities, and organizations.

In terms of order of discourses, Table 9 illustrates the discourses and the orders of discourses from the health promotion perspective. Note that the discourses are distributed according to the three approaches to health promotion (medical, behavioral, and socio-ecological). This might mean that the annual reports are more comprehensive

in respect to its health promotion focus. In respect to the OE order of discourses, the annual reports focused on inter and extraorganizational dimensions (see Table 10) because they emphasized relationships with other organizations and the dissemination of knowledge.

Table 9

Order of Discourses of the Annual Reports: Health Promotion Approaches

Order of discourse / **Sub-discourses**	**Medical approach**	**Behavioral approach**	**Socio-ecological approach**
Increasing knowledge and building capacity	✓	✓	✓
Resource	✓	✓	✓
Collaboration	✓	✓	✓
Health prevention		✓	
Championing the SDH			✓
Scientific	✓		
Improving internal capacity		✓	

Table 10

Order of Discourses of the Annual Reports: OE Processes

Order of discourse / **Sub-discourses**	**Intra-organizational processes**	**Inter-organizational processes**	**Extra-organizational processes**
Increasing knowledge and building capacity		✓	✓
Resource			✓
Collaboration		✓	
Health prevention		✓	✓
Championing the SDH		✓	✓
Scientific		✓	✓
Improving internal capacity	✓		

Annual reports' voices. I identified two central voices within the annual reports: (a) *expert* and (b) *proud voices*. These voices represent the way the annual reports seem to portray the organization in the health promotion field. Just like in the focus groups, the *expert voice* represents the way the organization represents itself as expert in the health promotion field. The expression of this voice within the annual reports is diverse; the reports have terms such as *expert* and *trustful*, the verbs *to empower* and *to help*, and

the nouns *specialist* and *credibility*. Those terms in the context of the annual reports seem to portrait the organization as an "expert" source of health promotion information.

The *proud voice* represents the positive language the organization uses to articulate their activities, achievements, and even their losses (usually, losses of funding or a "goodbye" for a staff or board member). This voice is common across the reports. The organization uses many words and phrases that allude to an optimistic view of the activities, and future prospects of the organization: *growth*, *commitment*, *excited*, *happy*, *stronger organization*, *significant accomplishments*, *increased services*, and *renewed energy*. Only recent annual reports describe some organization's "losses" (usually loss of funding, a farewell to a colleague, or the closure of a program). The organization, when describing these losses, usually reports this news among positive achievements. However, one particular report (2008/2009 report) contrasts the other reports by having a whole paragraph detailing a loss of funding and a closure of a program.

Linked to the *proud voice* is the *emotional voice*. In describing some of the organization's activities, the annual reports present terms that translate a personal connection among the organization members and the programs, clients, and partners. Some terms used are: *dear*, *near to our hearts*, *dedication*, and *pleasure*. The *emotional discourse* was identified in recent reports, usually among the descriptions of the organization's losses.

Summary of the annual reports' voices. Through the annual reports, the organization represents itself as an expert in the health promotion field and intrinsically connected with its activities. Furthermore, a general sense of optimism and pride permeates the reports; this pride enhances the *expert voice* when the reports translate a sense that the organization has both expertise and energy to perform its activities.

Summary of the Chapter

In this chapter, I have presented the themes, genres, discourses, and voices of the focus groups and the annual reports of the studied organization. This analysis represents the range of participants' understandings of empowerment as well as the practices of empowerment within the organization. Appendix K presents a diagram that summarizes the genres, themes, discourses and voices of the focus groups and its relation to the second step of the critical discourse analysis framework. Appendix L shows the same type of diagram, but for the annual reports.

The next chapter addresses the three final steps of the Chourialaki and Fairclough's (1999) framework. Within these steps, I discuss the implications of the themes, genres, discourse, and voices in the organization's activities, in light of the analysis of the conjuncture and practices. Furthermore, I begin to challenge the participants' and annual reports' assumptions on empowerment and health promotion by examining the discourses from socio-ecological and empowerment perspectives. I also suggest some ways to address problematic aspects of the organization's practices by bringing together the literature on social action and praxis.

Chapter 5: Discussion and Conclusion

This chapter discusses steps three, four, and five (i.e., the final steps) of the Chourialaki and Fairclough's (1999) five steps CDA framework. The third step refers to the analysis of how the discourses help to maintain the identified problems in the way it is. The fourth step discusses possible ways to resolve the problem and implications to future research. Finally, the fifth step is a reflexive discussion about the analysis. This last step explores some limitations of this study and the potential contributions of this study for health promotion and empowerment.

The problem identified in this study is whether a lack of a shared understanding of empowerment among professionals of a health promotion organization is problematic for their practice of addressing health inequities. In the analysis of the conjuncture, I have identified three orders of discourses at an organizational empowerment perspective: (a) intraorganizational; (b) interorganizational, and (c) extraorganizational orders of discourses. I have also identified three orders of discourses at a health promotion perspective: (a) medical, (b) behavioral, and (c) socio-ecological orders of discourses. In the analysis of practices, I identified that the focus groups were a research practice which entailed different motivations and desires among the participants (including the researchers). Finally, in the analysis of the discourses, I identified that the staff and board members have divergent conceptualizations of empowerment; the staff members highlighted internal processes of empowerment (intraorganizational order of discourse), whereas the board members emphasized inter and extratorganizational processes of empowerment. It was also identified that the annual reports focused on intra, inter, and extraorganizational processes of empowerment. In terms of health promotion orders of discourses, I identified that the majority of the staff members' and annual reports' discourses are under the behavioral approach to health promotion.

However, the board members' discourses embraced both behavioral and socio-ecological perspectives of empowerment. In what follows, I will discuss why these discourses might work as barriers to resolve the identified problem.

Step 3: Function of the Problem in the Practice

Chourialaki and Fairclough (1999) wrote that step three of the CDA framework is "the shift from explanation of what it is about a practice that leads to a problem, to evaluation of the practice in terms of its problematic results" (p. 65). To undertake this step, Fairclough (2003a) encourage the researcher to "consider whether the social order... in a sense 'needs' the problem. The point here is to ask whether those who benefit most from the way social life is now organized have an interest in the problem not being resolved" (p. 210). To that end, I examine how the discourses and voices identified in the focus groups interviews and the annual reports help to maintain the problem. This step will be divided in two major sections: (a) participants' conceptualizations and practices of empowerment; and (b) tensions between the participants' understandings and practices of empowerment. These two sections represent the focus of this study: the participants' understandings and their practices of empowerment.

Participants' understandings and practices of empowerment. The multiple discourses identified in the focus groups represent the diverse conceptualizations of empowerment among the professionals of a health promotion organization. For example, some staff members focused on intraorganizational and behavioral elements of empowerment (represented by, for instance, *knowledge base*, *collective ownership*, *sense of inclusion*, and *managerial discourses*). On the other hand, the board members emphasized extraorganizational and behavioral features of empowerment, embraced by the *providing information discourse.*

In studies developed by Appelbaum, Zinati, MacDonald, and Amiri (2010), Foster-Fishman, Salem, Chibnall, Legler, and Yapchai (1998), and Piper (2010), it was found that professionals in the same health organization have different understandings of empowerment. While these researchers have considered these differences problematic, it seems that this diversity was not a source of problems to the staff and board members who participated in this study because there was little tension among them with respect to their different conceptualizations of empowerment. Conversely, for the staff and board members, their problems lie with the empowerment conceptualizations of external institutions (mainly government and funders) and the influence these institutions have on the organization's activities. Thus, it is possible to imply that the organization's members in this study removed the focus from them and maintained their conceptualizations of empowerment unchallenged. The participants did not address some underlying assumptions of their understandings of empowerment (e.g., the fact that providing information is in line with a behavioral approach to health promotion) and relevant power relation issues (e.g., the relationship between staff and board members as well as new and old staff members). The participants' discourses resonate with the idea that, in discussing empowerment, "health promoters have offered surprisingly little analysis of power-relations as they pertain between, for instance, expert and non-experts, populations of the wealthy 'developed' countries and populations of the poor 'developing' countries..." (Petersen & Lupton, 1996, p. 10).

In terms of the organization's practices of empowerment, the participants, as well the annual reports seem to detail a practice in line with medical and behavioral approaches to health promotion. For example, the annual reports often focused on programs that target population's behaviors and attitudes, and specific diseases or conditions. This is problematic when the organization has a mandate to promote health

by reducing health inequities, for which the literature suggests socio-ecological approaches. In what follows, I advance this discussion by first exploring the staff members' focus group data. Next I bring together the board members and annual reports conceptualizations of empowerment.

Staff members' understanding and practices of empowerment. As previously mentioned, the staff members' understandings of empowerment emphasized intraorganizational processes of empowerment (i.e., sense of inclusion, construction of knowledge base, working environment, resilience processes, and felling of appreciation and acknowledgement). Also, the staff members seem to have a shared notion of empowerment, in which the practice of empowerment is constructed through mutual agreement, shared values, horizontal managerial processes, and personal connections[18] among the staff members. These aspects are consistent with current literature on health promotion and empowerment. Pendleton and King (2002) argue that team relationships are effective when the individuals share common values. In the organizational empowerment (OE) literature, it is emphasized that the sense of shared values is central for the development of empowerment strategies (Appelbaum et al., 2010; Hughey, Peterson, Lowe, & Oprescu, 2008; Maton & Salem, 1995; Peterson & Zimmerman, 2004; Spreitzer, 1995). These discourses are also in line with the idea of empowering organizations, in which the organization enables individual empowerment among its members (Peterson & Zimmerman, 2004).

Although I agree that these aspects might be important for the organizations' internal processes of empowerment, the staff members may have dismissed some relevant power relation issues. For example, the relationship between the *new* and *old* staff, the relationship between board and staff members, and, more broadly, relations

[18] The *emotional voice* identified in the annual reports seems to enhance this personal connection among the organization's members because it highlights the close relationship between the organization and its members.

among the organization, government, other organizations, and funding agencies may have been undermined. Many have claimed that empowerment processes that avoid challenging the power's status quo may legitimize authoritarian and unequal state of affairs (Carvalho & Gastaldo, 2008; Ferreira & Castiel, 2009; Riger, 1993; Stevenson & Burke, 1991).

The *resilience discourse* is another way by which staff members might obscure power struggles. In this discourse, the staff members represented themselves as strong to deal with the difficulties they face[19]. This perception might be relevant for their routine work (Laschinger, Finegan, Shamian, & Casier, 2000; Lofy, 1998; Maton, 2008), but it might hinder power struggles when, for example, instead of questioning the funders' decisions to withdraw its support for an organization's program, the staff members emphasized their resilience in dealing with the resulting job losses. Since this discourse relies on the individuals' capacity to face the problem, the *resilience discourse* also may reinforce the neo-liberal "celebration of individual responsibility" (Bourdieu & Wacquant, 2001, para. 6). Further, Collinson (2003) suggests that placing a great deal of responsibility on the individual extols individualism, competitiveness, alienation, not to mention job insecurity, anxiety, and conformism. By critiquing this *resilience discourse*, I am not suggesting that resilience processes should be avoided within organizations. Instead, the idea is to underscore the impact of both individual and structural processes on the professionals' work, as Labonte (1994) synthesized:

> Unless professionals think simultaneously in both personal and structural ways, they risk losing sight of the simultaneous reality of both. If they focus only on the individual, and only on crisis management or service delivery, they risk privatizing by rendering personal the social and economic underpinnings to

[19] The *proud voice* identified in the annual reports confirms this resilience attitude among the staff members because it highlights the fact that the organization remains strong and committed to its deliverables even during a difficult time, such as funding losses.

> poverty and powerlessness. If they only focus on the structural issues, they risk ignoring the immediate pains and personal woundings [*sic*] of the powerless and people in crisis. (p. 259)

In respect to the practices of empowerment, the staff members celebrated the fact that their management structures are horizontal, which enables a positive and supportive working environment (Hughey et al., 2008). In addition, the staff members seem to be personally connected with their colleagues, which, according to Laschinger et al. (2000), might enhance their commitment to the organization. The *managerial discourse* is consistent with findings from business and management studies (Barrett, Plotnikoff, & Raine, 2007; Honold, 1997). For example, as Durvall (1999) claims,

> Empowerment is possible only through strong (but not domineering) leadership.... Empowerment thrives on the identification of and adherence to boundaries. Boundaries are the results of a control effort. However, this control comes not from a person with authority dictating boundaries, rather the boundaries are defined from the empowered group of individuals committed to mutually agreed upon goals and objectives. (p. 211)

Durvall exemplifies the centrality of the management and leadership positions in the organizational empowerment strategies in business and management studies. As Morley (1995) points out, the empowerment strategies in business and managerial literature focuses on the ability of managers and other leadership personnel to share their power with the others, and not the ability of the staff to build their power around their working process. This critique resonates with the fact that, although the staff members agreed that their relationship with the management is horizontal, they also affirmed that the organization's culture was built around the managers' leadership. Ultimately, it seems

that the participants have taken for granted the relationship between managers and other staff members by dedicating little attention to the power aspects of this relationship.

It is also important to highlight that the *managerial discourse* along with the *knowledge base* and *working environment discourses* imply a continuation of the organization's practices from one generation to another. Although it seems reasonable to conclude that this continuity might be relevant to the working conditions within the organization, it may also suggest a construction of consensus among the employees, which in turn might mean a unified – and appropriate – way to behave and communicate (Sykes, Willig, & Marks, 2004). Further, Stotz and Araujo (2004) question empowerment processes as the construction of an agreement among the interested groups because it might conceal power struggles.

Although the participants, in general, did not address some relevant power relation issues for empowerment processes, they certainly have explored other important topics[20]. These are represented by the following discourses: (a) *employee status*, (b) *role expectation*, (c) *felling on top of things*, and (d) *check out health*.

The *employee status discourse* recognized that the type of contract that staff members have with the organization might change the way they experience empowerment. As a staff member remarked, there are inequalities in the staff members' contracts with the organization, which might have consequences to the employees' power status in the organization. Collison (2003) suggests that

> contemporary practices in 'post-bureaucratic' organizations that utilize new technologies to render work more flexible, contract-based, casualized [*sic*] and 'nomadic' can also intensify employee insecurities.... [these] insecurities crucially

[20] According to Chouliaraki and Fairclough (1999) and Lupton (1995), people's tendency to, at the same time, legitimize and reject power structures are a characteristic of contemporary societies.

> impact on the selves and subjectivities that currently shape modern workplace practices. (p. 531)

As a result, the way in which a staff member is part of the organization seems to be important because the type of contract between the individual and the organization may cause, for example, different relationships among the organization's members, and consequently, may impact the staff members' experience of empowerment.

The *role expectation discourse* highlighted the role of the cultural norms and personal background that staff members may bring to the working environment. Some researchers acknowledge the link between cultural background and working relationships (Griffith et al., 2010; McEwan, Tsey, McCalman, & Travers, 2010) as well as cultural background and social relations and empowerment (Airhihenbuwa, 1994; Williams & Labonte, 2007). It is beyond the scope of this study to detail the cultural aspects of the empowerment processes, but Anderson, Reimer Kirkham, Browne, and Lynam (2007) remind us that, when the issue of culture is brought into Canadian settings, it generally evokes issues related to non-western cultures. This may mean that the current western culture remains unchallenged when, in fact, both cultures should be discussed (Anderson et al., 2007). Indeed, during the focus groups, a staff member compared a non-western society culture with the Canadian workplace culture, without challenging the latter.

The *feeling on top of things* and *check out health discourses* highlight the heavy workload, poor health, and a decreased sense of empowerment felt by the staff members. The idea that the workload affects the health of the employee is present in the health literature, particularly if connected with burnout (Greco, Laschinger, & Wong, 2006; Hatcher & Laschinger, 1996; Joly, 1998; Laschinger, Sabiston, & Kutszcher, 1997; Schulz et al., 2011). Many studies have suggested that empowerment strategies

within the organization may prevent employees' burnout and other health-related issues (Arneson & Ekberg, 2005; Hatcher & Laschinger, 1996; Joly, 1998; Laschinger et al., 1997; Larrabee et al., 2010). However, it should be taken in consideration that these studies focus on management and employee empowerment to overcome the stress of the environment (mainly relying on their resilience), with little accent on the importance of changing the environments[21] (Awa, Plaumann, & Walter, 2010). Similarly, during the staff member focus group, while some participants showed concerns about others' experience of empowerment under a heavy workload, others highlighted their own resilience to meet the organization's challenges. By placing the responsibility on the individual for coping with their stresses and health conditions in the workplace without acknowledging and addressing the role of the environment on these processes, the participants might legitimize the individualism and awkward working conditions in the workplace (Collinson, 2003).

The *questioning the power discourse*, which represents the challenge that some participants presented to the others' understandings and practices of empowerment, was identified in both focus groups. But, the fact that these challenges did not reverberate around the focus group discussion nor broke the positive atmosphere in both groups might mean that these challenges are secondary.

In what follows, I discuss the conceptualizations and practices of empowerment from the board members' and the annual reports' perspectives.

Board members' and annual reports' understandings of empowerment. The conceptualization of empowerment identified in the board members' focus group and the annual reports included processes of providing information for enabling individuals and communities to be responsible for their health. For the board members as for many

[21] According to Collinson (2003), heavy workload is a characteristic of contemporary workplaces, not an individual matter.

authors, the provision of information is an empowering intervention (Chang, Li, & Liu, 2004; Lopez et al., 2007; Piper, 2010; Rodwell, 1996; Travers, 1997; Wallerstein & Sanchez-Merki, 1994; Wang & Burris, 1994). Others researchers have argued that the main goal of health promotion programs is to provide information about, for example, management of certain diseases (Releford, Frencher Jr., Yancey, & Norris, 2010) and conflict resolution and negotiation skills "for fostering empowerment and enriching the political life of members in the face of dominant... discourses" (Trethewey, 1997, p. 300). Lastly, Peterson and Zimmerman's (2004) framework describes the dissemination of information as an extraorganizational process of OE. Yeo (1993) suggests that the idea of information as empowerment comes from the assumption that "if properly informed and persuaded, people can change their behaviors to assume greater responsibility for their health" (p. 228). Nevertheless, this assumption might be consistent with the "victim-blaming" approach (Lupton, 1995), since the individuals are considered to be ultimately responsible for changing their behavior and control their life (Piper, 2010; Yeo, 1993).

The outcomes of the information giving process, as depicted by the board members, are consistent with what Piper (2010) suggested: "with empowerment comes improved self-esteem and confidence, an ability to exercise choice, accept responsibility for health and resist external pressure to pursue a particular course of action" (p. 176). Framed this way, the outcomes of the information giving processes might confirm Carvalho and Gastaldo's (2008) suggestion that empowerment strategies might turn into a sophisticated form of self-govern, in which the disadvantaged population is responsible for advocate for their health, while the advantaged population maintain their status. In addition, it is argued that increased self-esteem, confidence, and acceptance of responsibility can make people feel better about a situation, but does not represent

actual changes in the systems that make their life bad (Carvalho, 2004; Ferreira & Castiel, 2009; Riger, 1993; Weissberg, 1999). In fact, comments by some staff members may illustrate this notion. In discussing the measurement approaches, some staff members agreed that their clients enjoy the organization's services, but the organization's members remains uninformed about whether the activities they perform are being effective to community change.

For many researchers, the idea of information giving may justify cuts in the health care system, since it is believed that, if individuals and communities are provided with sufficient information, they are now responsible for maintaining their health (Carvalho, 2004; Poland, Coburn, Robertson, & Eakin, 1998; Robertson, 1998). During the focus group, a board member criticized the universal health care system and suggested that "at societies where every time you go to a doctor you have to pay (...) there is more an incentive on you to stay healthy and be healthy". In certain ways, this participant may have expressed a call for cutbacks (or at least significant changes) in funding for the health care system. Robertson (1998) explains the inconsistencies of these cutbacks with the current call for health promotion approaches to reduce health inequities:

> The removal of resources from the health care sector... can only penalize further those whose health is already compromised by underlying structural inequities. And, if, as a society, we are not prepared to do anything about those underlying structural inequities, then ensuring equitable access to health care, at the very least, represents an acknowledgement that these inequities do exist. Universal publicly funded access to health care stands as a powerful political symbol of our commitment to the moral economy of collective provision which lies at the heart of what it means to be a community. (pp. 163-164)

Thus, the advocacy for funding changes in the healthcare system may signify a further widening in health inequities, which is exactly what the studied health organization, allegedly, works against.

In terms of empowerment practices, this information giving approach has been criticized because, as Sykes et al. (2004) put it, "once a health message has been disseminated, health promoters discharge their responsibility and the emphasis turns to the individual to act upon this knowledge to prevent illness" (p. 132). Moreover, this *providing information discourse* resonates with the idea that the provision of information considers the population as a passive recipient of the "appropriate" knowledge (Lupton, 1995, p. 60; see also Stotz & Araujo, 2004; Sykes et al., 2004). The provision of appropriate information is also consistent with Freire's (1993) notion of banking education, where learners are passive recipients of the knowledge that the educators want to impose on them. Thus, the *providing information discourse* might imply the population as "incapable of their own powerful actions" and the organization as the "controlling actors" of the interventions (Labonte, 1994, p. 255).

Also relevant is the idea that empowerment as information giving processes implies that the type of knowledge that the organization has is, in any form, superior[22] (Petersen & Lupton, 1996). This resonates with the *expert voice* identified in the focus groups and annual reports. The view of health promoters as experts might be detrimental for the relationship between these professionals and their clients. For Sykes et al. (2004),

> the health promotion community (or 'experts' and practitioners) and the public are seen as two different entities that need some form of modern technology to communicate. This conjures up an image of health promotion experts existing in

[22] Business commentators support the idea that the experts "must lead to performance that is consistently superior to that of the expert's peers" (Ericsson, Prietula, & Cokely, 2007, p. 117). Thus, the *expert voice* resonates with the managerial discourses identified earlier in this discussion.

> one box and the public in another, both far removed from each other yet 'modern technology' is going to somehow bring these groups closer. (p. 137)

This notion of the organization as an expert also might undermine the ability of communities and individuals to actually take ownership of the processes of change, because the strategies to trigger the change are outside of the communities and individuals governance (Robertson & Minkler, 1994). As a result, the fact that the organization displays itself as an expert may distance the organization from its clients.

In contrast with the *expert voice* is the board members' reasoning to shift the attention from the term *help* to the term *enable*. The board member who emphasized this difference articulated that the word *help* is patronizing, while the word *enable* focuses on strengths. This echoes with a quotation from an Australian Aboriginal woman: "if you are here to help me, then you are wasting your time. But if you come because your liberation is bounded up in mine, then let us begin" (as cited in Labonte, 1996, p. 258). Thus, health promotion interventions can have a downside if health promoters aim to help the population without considering the knowledge and experiences of the people they are working with. Interestingly, a staff member called our attention to the idea that that the verb *to empower* has also been considered patronizing. This connotation was never underlined by the board members[23] and similar consideration about the verb *to empower* has already been claimed by some health promotion scholars (Labonte, 1994; Wallerstein & Bernstein, 1994). Thus, these examples demonstrate the participants' awareness of the importance of the vocabulary in the health promotion ideas and practices since the words we use might validate the actions we perform (Fairclough, 2003a).

[23] Actually, some board members utilized the verb *to empower*.

It is important to note that one cannot undermine the power of health information. As Piper (2010) suggested, "information giving... is not empowering per se, or in any way an empowerment endpoint" but people cannot be empowered without information (p. 176). Researchers and practitioners claim that individuals' and communities' lack of knowledge about health processes are part of their problems (Flynn, Ray, & Rider, 1994; Lopez et al., 2007; Rodwell, 1996). The issue, though, is to believe that the provision of information is enough to enable empowerment in individuals, professionals, and communities.

In what follows, I discuss two considerations pertaining both focus groups: (a) the difference between staff and board members' discourses, and (b) the little attention the participants gave to the *control over discourse*.

Considerations about the difference between staff and board members' discourses. As pointed out in the Chapter 3, this case study assumed that the conceptualizations of empowerment would be different between staff and board members because their role in the organization is diverse. As can be noted, this assumption was confirmed. The staff members focused on intraorganizational aspects of empowerment, while the board members emphasized the extraorganizational dimension. The potential explanations for this difference are consistent with Barrett et al.'s (2007) argument:

> Board members...typically have reduced contact with operational processes and conditions given their primary focus on governance functions (e.g., setting policy framework and directions; establishing and monitoring the annual business plan, etc.). Therefore, board perspectives can be expected to be quite different compared to middle/senior managers and frontline practitioners who are more directly involved in processes related to health service implementation. (p. 275)

This might explain the different emphasis of the two groups, but it does not mean that this difference is unproblematic. It was beyond the scope of this study to examine the relations among the organization's members; however, these differences in conceptualization of empowerment demonstrate that some issues (such as the outcome of their empowerment strategies) might not have been resolved among the organization's members. One should recognize that the relationship between the staff and board members is a power relation (Fairclough, 2002), which needs to be debriefed in order to avoid triggering detrimental conceptual and practical conflicts among the organization's members (Minkler, Thompson, Bell, & Rose, 2001; Rissel, 1994). I am not suggesting that the organization should avoid (or control) conflicts; rather, I am emphasizing the need to enable spaces in which these conflicts are addressed.

Considerations about the control over discourse. The majority of the empowerment concepts within the health promotion literature is related to the term *control over* (see Chapter 2). Considering that this term has been widely used in the health promotion literature, surprisingly, little attention was given to this term during the focus groups. Indeed, it seems the participants' discourses were more related with everyday expressions (as represented by the *ordinary life voice*) than connected to academic terminologies. This contrasts with the *scientific discourse* identified in the annual reports.

Although the *sense of inclusion, appreciation and acknowledgement*, and *providing information discourses* can be related to issues of control (Peterson & Zimmerman, 2004), the simple fact that the *control over* term was not emphasized by the participants is of significance. It is, however, beyond the scope of this analysis to explore why the participants rejected this term, but this fact might indicate that this term does not represent the participants' ideas of empowerment.

Some health commentators critique the *control over* term by claiming that this term is paternalistic and individualistic (Lupton, 1995), and patronizing (Braunack-Mayer, & Louise, 2008). Also, Petersen and Lupton (1996) argued that "permitting autonomous local control over resources when resources are unequally distributed among locales is likely to produce exploitation rather than justice" (p. 148). Thus, this term has been controversial in the literature.

Also interesting is the fact that a staff member said that empowerment is "the sense of control that one *feels* or *has* over parts of their life". This participant has used the verbs *to feel* and *to have* to talk about empowerment which may imply that empowerment may be either a sentiment or a possession, either abstract or concrete. It is worth to note this duality because some researchers critique the notion of empowerment on the basis that empowerment may be seen as a way to feel better about a situation, not a concrete change in people's reality (Carvalho, 2004; Weissberg, 1999). As such, in terms of health equity, the population needs an actual advance in their social status, rather than improved feelings about their environment (Commission on Social Determinants of Health, 2008).

In the next section, I continue this discussion by focusing on the tensions between participants' understandings and practices of empowerment as identified in the participants' discourses.

Tensions between the participants' understandings and practices of empowerment. This section discusses some tensions in the participants' and annual reports' discourses that might hinder empowerment processes. As represented by the *resistance discourse,* medical power, Canadian culture, and measurement approaches are some of the matters that, for participants, constrain empowerment strategies within and outside the organization. As noted previously, this discourse entails socio-

ecological aspects of health promotion and empowerment because it considers cultural and political aspects of empowerment. These socio-ecologically oriented discourses contrast with the behavioral focus of participants' understandings of empowerment. Thus, the participant (mainly the board members) discussed a dual approach to health promotion, one which pays attention to both the socio-ecological approaches (represented by the *resistance discourse*) and the behavioral approaches (represented by the *providing information discourse*). Also representative of the organization's practices is the annual reports because they describe behavioral approaches to health promotion with a focus on the health prevention discourse.

This dual approach to health promotion – a paradox, in Lupton's (1995) terms – may represent quite well the current health promotion state of affairs in Canada. This ambiguity may confirm Lupton's prediction that, although the health promotion rhetoric entails social change and challenges the status quo, its practices are still limited in their scope because they emphasize behavioral approaches. I suggest that the fact that the organization was founded in a period of time where the disease prevention and behavioral change approaches were hegemonic might explain this duality. As Robertson (1998) points, behaviorist approaches dominated health promotion interventions in Canada during the 1970s and 1980s, exactly the period in which the organization was founded. Although this might explain why the organization initiated its activities under a behaviorist mandate, the recent call for social change to reduce health inequities requires different approaches, which seem to have been incorporated in some discourses but not in the organization's actual practices.

Another ambiguity with the board members' discourses can be identified in two additional discourses: *Canadian culture* and *cultural change*. On one hand, the board members concurred that the Canadian culture is a factor that contributes to the

detrimental influence of the medical power on the health system. On the other hand, they claimed that cultural change is not within the scope of organization's activities (the *pessimistic voice* identified in the board members' focus group enhances this paradox since they articulated that, for many reasons, it would be very difficult to change the Canadian culture). Again, this ambiguity may contribute to maintain the status quo instead of advocating for actual change in the culture, which has been stated as a social determinant of health (Mikkonen & Raphael, 2010).

Buchanan (2000) has argued that there are two interconnected processes that maintain the hegemonic status of behavioral approaches in the health promotion field: (a) governments and funding agencies often support interventions that fit in behavioral approaches, and (b) these same government and funding agencies also demand interventions that are founded on evidence-based theories. Since some participants touched on these two ideas, I will expand the discussion.

The issue of funding for health promotion strategies. Governments and funding agencies support health promotion interventions that embrace behavioral change and disease prevention approaches (Buchanan, 2000; Laverack, 2006). Linking this situation with the fact that the organization of this study is heavily supported by government and public agencies, it is reasonable to imply that this may explain the organization's position. Interestingly, a board member recognized that the organization's funding mandates indeed limit its activities, supporting Sparks' (2009) claim that professionals working in organization funded by the government may "find it difficult or impossible" to work against an institution that support their activities (p. 200). Thus, the organization faces a situation where, while it advocates for social changes to promote health and reduce health inequities, it also must comply with limited mandates set by government. One interesting point is that this bound of the organization to the

government funding resources resonates with Stevenson and Burke (1991) and Lupton' (1995) thoughts that the current health promotion is a bureaucratic movement, born within the state, not a social movement, as it was alleged by Robertson and Minkler (1994). The participants of the focus groups and some authors (Labonte, Woodard, Chad, & Laverack, 2002; Laverack, 2006) have argued that a balance between the organization's goals and the funders' mandates should be achieved. However, as Carey and Braunack-Mayer (2009) put it, "the effects of government funding and the search for organizational legitimacy may be prohibitive to finding such a balance" (p. 51).

The issue of the evidence-based health promotion. Staff and board members were critical of the way that health promotion interventions are currently being measured by claiming that government and funders require restricted ways to assess their activities (e.g., number of brochures or workshops given). For the participants, these methods are more in line with the medical tradition. By making these comments, the participants touched on a controversial matter in the health promotion field, which is the measurement approaches to health promotion interventions.

The measurement discourse in the health promotion literature is contingent upon the individuals' paradigm. While some researchers advocate for research in health promotion centered in quantitative research methods such as the randomized control trials (Crawford Shearer, Fleury, & Belyea, 2010; Jackson & Waters, 2005; Kulbok & Baldwin, 1992), others recognize that this approach is not consistent with the type of knowledge that is required to promote health (Buchanan, 2000; Goodson, 2010; Labonte & Robertson, 1996; Porter, 2007). As Sykes et al. (2004) suggest, the evidence-based approach "values research that positions people as subjects to be observed and measured and it values evaluations of outcomes. Thus, no allowance is given to how people feel about certain issues in health promotion" (p. 140).

Nevertheless, as Robertson (1998) and the participants of the focus groups concurred, the quantitative methods are still dominant in the health promotion literature and practices; as a result, the current measurement approach fails to evaluate matters that are valuable for the health promotion interventions at the socio-ecological perspective, namely community change and empowerment processes.

The consequences of this evidence-based approach are illustrated by the participants of the focus groups: for example, the government sets up its measurement approach by keeping statistical accounts of internet hits in the organization's website or how many brochures were distributed. Furthermore, the restricted evaluation forms that the organization has to comply with, as suggested by the participants, limit the organization's assessment of its activities and avoid the construction of more complex types of knowledge.

Contrasting with some participants' criticism about the evidence-based approach demanded by government and funding agencies, the annual reports entailed the *scientific voice*. The annual reports seem to include terms and expressions that allude to traditional scientific methods, such as systematic assessments and best practices. On the other hand, the participants were more in line with a constructivist approach to evaluation when they advocate for a type of evaluation that "tells a story" (Labonte & Robertson, 1996, p. 436). Thus, one can imply that, again, the incorporation of the *scientific voice* in the annual reports may be a necessity to comply with funders' requests; however, by doing that, the organization legitimizes a more conservative and limiting approach.

Another problematic result of the evidence-based approach to health promotion is its tendency to "medicalize" health promotion. A number of authors highlighted that the evidence-based health promotion (and its mandate to reduce, control, and experiment)

turn diseases and illness the focus of the health promotion intervention (Buchanan, 2000; Sykes et al., 2004; Labonte & Robertson, 1996). Indeed, Porter (2007) argued that the 2005 Bangkok Charter for Health Promotion represents a "shift... from socially proactive to biomedically defensive health promotion" (p. 77). While annual reports adopt a *scientific voice,* the participants of the focus group criticized the "medicalized" approach to health promotion. Again, this divergence may represent the naturalization of a practice that is detrimental for the socio-ecological health promotion.

Summary of the Step 3: Function of the Problem in the Practice. As the preceding sections demonstrated, the staff and board members', and annual reports' discourses emphasized the behavioral approach to health promotion and empowerment. Also, the discussions about empowerment provided little analysis of power relations. This may reflect on practices that legitimize the status quo and make social change intangible. Although there are significant differences between the staffs' and board members' understandings of empowerment, the limited scope of the empowerment conceptualization of both groups shifted the initial problem proposed in this case study, from professionals of a health promotion organization having different understandings of empowerment to professionals of a health promotion organization having reductionist understandings of empowerment.

Step 4: Possible Ways to Surpass the Obstacles

The fourth step in Chouliaraki and Fairclough's (1999) model is a continuation of the previous one. While step three focused on how the problem works in the social practices, step four aims to outline some ways to overcome the problem. As stated by Chouliaraki & Fairclough, (1999), "if the practices are flawed, then we ought to change them" (p. 65). To propose some ways to overcome the problem, in this section I will focus on the work of two authors: the Brazilian educator Paulo Freire and the American

health commentator David Buchanan. More specifically, I will draw attention to Freire's notion of praxis and Buchanan's advocacy for a new ethic in the health promotion field. Although I acknowledge that other authors would enrich this discussion (e.g., Goodson, 2010; Lupton, 1995; Petersen & Lupton, 1996), I believe these two authors synthesize some central ideas that may serve to advance the organization's practices.

For Freire (1993), praxis is the ongoing process of action and reflection upon the action. The importance of this process lies on the idea that practice and reflection are intrinsically related, which turns the state of being in the world both practical and reflexive matters. In addition, to exercise praxis, people need to raise their consciousness about the world, which means to acquire knowledge to critically act and reflect on the world[24] (Freire, 1993). The type of knowledge that individuals acquire changes their perceptions of the world (Freire, 1993), which accentuates the importance of where and how individuals are searching for new knowledge. As a result, when a group exercises praxis, it means that they are acting and reflecting on their actions through a curious and radical lens, always questioning and critically analyzing their practices.

The question of where individuals acquire their knowledge is central in Buchanan's call for a new ethic for health promotion. Since the main types of knowledge that the health promotion field are consuming are based on positivistic and reductionist ways to see the world, consequently their proposed health promotion practices will reflect these assumptions (Buchanan, 2000). This leads practitioners to reproduce certain actions that are inconsistent with the purpose of the socio-ecological perspective of health promotion. For example, the evidenced-based approach to health

[24] Freire believed that a human being is "an uncompleted being conscious of his incompletion" (Freire, 1993, p. 27), meaning that individuals' aspiration for new knowledge is ontological and continuous.

promotion assumes that the target of change should prioritize diseases and human behaviors, which can be controlled, experimented, and, consequently, manipulated; so, the role of the health promotion becomes to put the evidence into practice (Buchanan, 2000). By performing and advocating for this perspective, researchers and practitioners neglect the basic moral principle of autonomy (Buchanan, 2006a; 2008). Accordingly, there is a clash between what the field is claiming to do – social action and justice to reduce health inequities – and what it is actually doing – manipulating and controlling diseases and human behaviors (Buchanan, 2000; 2006b). Buchanan (2000) claims that health professionals should redirect the source of their knowledge, seeking answers for their questions based on humanistic and ethical principles, such as justice, caring, and responsibility[25]. Instead of advocating for people changing uncritically their behaviors, professionals "might consider the extent to which human beings achieve a sense of well-being through living lives of personal integrity and pursuing life projects that connect them to transcendent values that bring meaning to their lives" (Buchanan, 2006a, p. 2722). It would, therefore, be more empowering (and ethically-sound) for the population to find meaning to their lives than to be informed about healthy foods, physical exercises, and lifestyle changes. As Freire (1998) states,

> It is an idealistic exaggeration, for example, to imagine that the objective threat that smoking poses to anyone's health and to my life is enough to make me stop smoking. Of course, the objective threat is contextually essential if I am to take any steps at all. But such a threat will only become a "subjective" decision to the degree that it generates new option that can provoke a break with past habits and an acceptance of new commitments: When I assume consciously the danger represented by smoking, I am then moved to reflect on its consequences and to

[25] Certainly, Freire (1993) would add love, hope, and humility to these principles.

> engage in a decision-making process, leading to a break, an option, which becomes concretized, materially speaking, in the practice of "not smoking", a practice grounded on the risk to health and life implicit in smoking. (p. 44)

The exercise of praxis along with redefinition of health promotion that include concepts such as justice, caring, responsibility, love, hope, and humility may advance the way health promotion and empowerment ideas are put in practice. Of course, it is important to highlight that these suggestions are elaborated here without the assistance of any organization's member. This means that, although they are grounded in the problem identified in this research, they are theoretical suggestions.

Research practices are also ways to contribute to the creation of new knowledge and ways of practice (Shor & Freire, 1986). Next section explores some areas of future research that may advance the health promotion and empowerment practices.

Implications for future research. As cited above, the search for new knowledge is an ontological condition of the human being (Freire, 1993). As such, research practices are one way to add new "bricks" to the "edifices" of knowledge (Forscher, 1963, as cited in Goodson, 2010, p. 41). However, it is important to be aware of what kind of bricks and edifice one desires to use and build. According to Goodson (2010), reflecting on what kinds of questions are being asked is more important than thinking about which methods are most appropriate to answering the research questions. Goodson (2010) proposed some questions that health promotion researchers and practitioners can ask themselves when intending to conduct a research:

- *What* have we been doing?
- *How* have we been practicing our profession?
- *Where* are we headed with our current ways of practice?
- *When* have we been effective? (p. 218, emphasis in original)

The answers to these questions may shed light to central issues in the health promotion research and practice and help researchers and practitioners to be mindful regarding their actions. To further explore the organization's understanding and practices of empowerment, the above mentioned questions can be asked through diverse research methods including:

- A critical discourse analysis of the toolkits, brochures, web-site, and other resources produced by the organization;
- Case studies utilizing observation, interviews, and document analysis approaches can also be useful to explore specific relationships between, for example, the organization and clients, or the organization and the funders;
- Ethnography research inquiries or institutional ethnography studies would also enhance our understanding of how the processes of empowerment and other social constructs flow within the organizational structure, clients, funders, and partners.

In terms of the broad field of knowledge on organizational empowerment and health promotion, some directions for further research can be proposed:

- Ethnography, case study, and grounded theory approaches can expand the OE framework set by Peterson and Zimmerman (2004) in order to further characterize the three dimensions of empowerment (i.e., intraorganization, interorganization, and extraorganization) and better define empowering and empowered organizations;
- A critical analysis of the interrelations between organizational empowerment, organizational studies, and business and management literatures would also enhance our understanding regarding the interplay among theses subjects;

- Exploratory studies which analyze the impact of public policy (including funding and measurement systems) on health promotion organizations' activities might also shed light to power relation issues within the health system.

In the next section, I present the last step of the Chouliaraki and Fairclough's (1999) critical discourse analysis framework, a reflexive analysis of the researcher's position in the research process.

Step 5: Reflection on the Analysis

In this last step of the framework, Chouliaraki and Fairclough (1999) are consistent with the broad epistemological assumptions of the critical theory paradigm. For critical theorists, to clarify the theoretical location of the researcher who carried out the study is central because the knowledge produced in this study is not neutral (Fairclough, 2003a; Kinchele & McLaren, 2005).

The first point I would like to make is the fact that this research was a theoretical exercise of my part, since I have not been in contact with the organization's members at the time of the development of the research project, the identification of the problem, and the analysis of the ways to overcome the problem. Despite my attempts to conduct this research in a more collaborative atmosphere, this task was unsuccessful[26]. As a result, although the identified discourses and voices were grounded in the participants' contributions, the organization was not involved in the various steps of this research. I recognize this as a limitation of the study, because some aspects of my discussion may not reflect the totality of the participants' ideas and practices of empowerment. As only a few members of the organization participated in the focus groups, the ideas expressed during the focus groups reflect the opinion of a fraction of the organization.

[26] Of course, it is important to reiterate that this research was not a participatory action research or an ethnography that would depend on the fully collaboration of the participants (Mahoney, 2007; Minkler, 1985).

Another point is that this research was conducted from a particular knowledge claim as outlined in the study methodology section. I do not see this as a limitation of the study, but I recognize that other paradigms and research approaches would generate different results. I also admit that organizational studies literature or additional publications from the health literature would also enrich this research with other ideas about organizational empowerment and health promotion.

My location as an outsider of the organization has also important implications for the study. The participants of the focus groups and I shared the interest in the health promotion field, but our practices and experiences, our cultural and professional backgrounds, and even our age groups were diverse. This means that the claims I made in this study, although based in the participants' contributions, were constructed from my outsider perspective.

Being an outsider researcher has advantages and disadvantages (Chad & Witcher, 2010). A benefit of my outsider perspective is that it might bring "fresh eyes" to the organization's discourses and practices (Dwyer & Buckle, 2009). As I had no previous connection with the organization's activities and the relationships between the participants, I was open to hear the participant's thoughts in the way they elaborated it, without previous assumptions that might have clouded my perceptions. I should highlight, however, that the fact that the organization and its members accepted to be part of the study, despite being aware of my outsider location, indicates that they did not see this condition as an impediment to the research process (Dwyer & Buckle, 2009) and the organization's willingness to an outsider's scrutiny. I see this as an advantaged location because the participants legitimized my outsider potential to bring some benefits for the organization. Another indication of the acceptance of this project was the fact that, during the focus groups, the participants seemed comfortable to share their

experiences and thoughts with someone who does not participate in the routine activities of the organization.

Despite the fact that my outsider location may bring benefits to the research process, I also have to acknowledge its drawbacks. Since I have never participated in any activity of the organization other than the focus groups, my location might have jeopardized my ability to analyze some particularities of the participants' context, such as their relationships with each other and with clients and funders (Dwyer & Buckle, 2009). It is important to note that it was not within the scope of this research to gather information on these relationships, although I grant that this data would have enhanced my understanding about the organization's practices. As such, this also can be seen as a limitation of this research.

My outsider location is not only in relation to the organization per se, but also with the profession, the country, and the language. Although I have some foreign working experience with health promotion and education, I have never worked in a place similar to the studied organization. The fact that I am an international student, coming from a country where English is not the native language, was also a challenge. My status as a second language user may have influenced the way I understand some language patterns and colloquialisms (Chad & Witcher, 2010; Mahoney, 2007; Sherif, 2001). Consequently, my outsider location certainly influenced the way I communicated with the participants and conducted my research. Of course, the inability to understand some expressions also occurs with English-language natives that conduct research in other English-language countries or even provinces (Chad & Witcher, 2010; Mahoney, 2007; Oliver, Serovich, & Mason, 2005) and with researchers who study people from different ethnic origin and social classes (Taylor, Mackin, & Oldenburg, 2008; Varcoe, 2006).

The issue of language also may have influenced the focus groups' transcriptions. As pointed out by Chad & Witcher (2010), "it is important to acknowledge the complexity of representation inherent in transcription and to disclose how the transcription process unfolds throughout the research process" (p. 123). Just after the first focus group, I initiated the transcriptions of the focus groups. This process, as envisioned, was long and challenging. A fact that facilitated the process is that the quality of the audio files was very good and all participants spoke in good pace and tone. The review of transcriptions by a native English user also enhanced my confidence that the transcription reflected the participants' interaction.

A final point of reflection is that this study represents the experience of a single health promotion organization in Ontario and as a result it does not intend to be generalized to other organizations. I do not see this fact as a limitation of the study, as the study was not designed or intended to produce a generalizable result, but I mention this point here to ensure that the aim of this study will not be misinterpreted. In what follows, I reflect on the implications of this study on the health promotion practice.

Implications for health promotion practice. This research may serve to guide various purposes in the health promotion practice. First, organizational empowerment is a concept which has been somehow neglected by the field, although the majority of the health promotion programs are delivered through organizations (Pilisuk, McAllister, Rothman, & Larin, 2005). Thus, this study may contribute to the further dissemination of this concept in the health promotion field.

Second, this research may help professionals in health organizations to think critically about their own assumptions when performing health promotion programs and realize how internal and external structures may impact their practices. As suggested by the participants of this study, government and public agencies influence how health

promotion is funded and, consequently, practiced. This demonstrates how health promotion may still be a bureaucratic movement, which depends on the government to perform its activities (Lupton, 1995). Ultimately, the awareness of this situation may be compared to the Freire's critical consciousness raising (Freire, 1993), in which people are not only knowledgeable about the structure in which they are part but also encouraged to put in practice their new knowledge. Lastly, this study hopes to shed light to the necessity for professionals continuously reflect on their rhetoric and their practices in order to achieve their goals of decrease health inequities. In the next section, I disclose some personal reflections on the process of this project.

Personal Reflections. The process of conducting this research was of great value for my personal development and I am thankful to have had this opportunity. As I disclosed earlier, my knowledge about empowerment concepts is relatively new, although I have already experienced its implications in my professional life. Through this study, I achieved greater understanding of the implications of power relations in my personal and professional lives. I have also realized that power relations are not necessarily domination; rather, sometimes power comes with caring and supportive ties. My awareness about the political, economic, and social structures that influence people's lives has also grown, and I developed a more critical understanding about the interconnections between myself, the others, and our social environment.

During the process of conducting this study, I also learned that addressing health inequities is a challenging and disputed process: many forces influence positively and negatively the practice of health professionals (and the people in general) toward a more equitable society. I also discovered that, concurrently, institutions, people, and organizations may enable and constrain the resolution of health inequities. It was interesting to note that ideas that once were considered progressive and libertarian can

also serve to oppressive and authoritarian purposes. Furthermore, I realized the importance of language and knowledge in legitimizing and overcoming this ambiguity. Now, I am much more aware of how words have diverse meaning depending on the context and the way I utilize these terms.

The practice of writing a research proposal and then undertaking the project also helped me to recognize the intrinsic relationship between theory and practice. Now I understand better how theoretical structures impact my life and work and the need to think critically about the assumptions I made before, during, and after my actions. This means that my practices result not only from my choices, agency, and personality, but also from my gender, family, social location, language, culture, profession, etc.

Finally, I immensely appreciate the support and commitment of all the people involved in this process. I sincerely enjoyed getting to know the professionals of the organization that participated in this study. I hope that this research can help us to move forward to better health promotion practices, in which empowerment can be seen as a way to bring people together to advocate for health equity.

Final considerations. For many years, empowerment processes have been deemed relevant for the health promotion field mainly because of their socio-ecological perspective. Organizational empowerment has been suggested as a process to foster empowerment both within and outside organizations. Past studies indicate that, generally, practices of empowerment are constrained by the fact that professionals working in a same organization have different conceptualizations of empowerment. The purpose of this study was to explore the understandings and practices of empowerment from the perspective of professionals working in a health promotion organization which has the mandate to reduce health inequities. Two focus groups with staff and board

members and annual reports were used as methods to gather the data. A critical discourse analysis approach was utilized to analyze the data.

The analysis suggested that the participants have different conceptualizations of empowerment; however, more problematic is the fact that these understandings emphasize behaviorist and bureaucratic notions of empowerment. As a result, their practices are focused on behavioral approaches to health promotion and little attention has been given to power relation issues, which diverge from the ultimate health promotion's goal of social, economic, and environmental changes that reduce health inequities. Paulo Freire's notion of praxis (Freire, 1993) and Buchanan's (2000) advocacy for a new ethic in health promotion may be elaborated as ways to overcome the problem. Ultimately, I hope that this study has shed light to the necessity to professionals continuously reflect on their discourses in order to advance their practices.

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Appendix A

Sample of the Charter Describing the Publications Included in the Literature Review

Reference	Title of the publication	Methodology	Origin of the author(s)	Main contributions
Carvalho (2004)	The multiple meanings of "empowerment" in the health promotion proposal.	Literature review	Brazil	Concept mapping of empowerment; critical perspective on the empowerment concepts to the development of health promotion and education strategies.
Gutierrez et al. (1995)	The organizational context of empowerment practice: Implications for social work administration	Qualitative case study	US	Suggest ways of working toward empowerment practices within organizations: staff development, collaborative approaches, safe environment, shared philosophy, management leadership.
Israel et al. (1998)	Review of community-based research: Assessing partnership approaches to improve public health.	Discussion paper	US	Advocate for community-based research with emphasis on integrating the generation of knowledge into strategies to provide community and social change.
Labonte (1992)	Heart health inequalities in Canada: Models, theory and planning	Qualitative case study	Canada	Describe a heart health strategy focusing on heart disease inequalities. Stresses the need to address individual, organizational, professional, and political will to move the program for outcomes that achieve the medical and social needs of the population with heart disease.
Laverack (2009)	Public health: Power, empowerment and professional practice	Book	New Zealand	Discussion about health, health promotion, and empowerment strategies. Need to involve government, community and organizations in developing programs. Several examples throughout the book on empowerment in health promotion interventions.
Peterson & Zimmerman (2004)	Beyond the individual: Toward a nomological network of organizational empowerment.	Discussion paper	US	Describes the nomological network of empowerment at the organizational level of analysis. Intraorganizational, interorganizational, and extraorganizational components of OE are examined.
Pilisuk et al. (2005)	New contexts of organizing: Functions, challenges, and solutions	Book chapter	US	Discuss that health organizations have special role in, for example, connecting community groups with public interest organizations, using the mass media for communicating empowerment strategies, overcoming divisiveness and promoting coalescence, and becoming part of a social movement.
Rifkin (2009)	Lessons from community participation in health programmes: A review of the post Alma-Ata experience	Literature review	UK	Evidence that community participation has made important contributions to health improvements, particularly among the poorer members of the population
Wallerstein & Martinez (1994)	Empowerment evaluation: A case study of an adolescent substance abuse prevention program in New Mexico	Qualitative case study	US	Case study of a program using empowerment strategy and a qualitative evaluation process.

Appendix B

Table Showing the Publications Included in the Literature Review by Theme and Geographical Origin of the Authors

Theme 1	References	Geographical origin of the authors
The centrality of health inequities to health promotion	1. 'The Copenhagen declaration on reducing social inequalities in health', 2002;	International*
	2. Braveman & Gruskin, 2003;	US
	3. IUHPE & CCHPR, 2007;	International
	4. Israel et al., 1998;	US
	5. Kjellstrom et al., 2007;	International
	6. Mundel & Chapman, 2010;	Canada
	7. PAHO, 2007;	International
	8. Poland et al., 1998;	Canada
	9. PHAC, 2003;	Canada
	10. Raphael, 2003c;	Canada
	11. Tones & Tilford, 2001;	UK
	12. K. D. Travers, 1997;	Canada
	13. Wallerstein, 2002;	US
	14. Wallerstein & Freudenberg, 1998;	US
	15. Whitehead & Dahlgren, 2006;	International
	16. WHO, 1978;	International
	17. WHO, 2005;	International
	18. WHO Task Force on Research Priorities for Equity in Health & WHO Equity Team, 2005	International
Theme 2	**Reference**	**Geographical origin of the authors**
Utilization of empowerment strategy within health promotion interventions	19. Barten et al., 2007;	International
	20. Becker et al., 2005;	Brazil
	21. Becker et al., 2007;	Brazil
	22. Bernstein et al., 1994;	International
	23. Braunack-Mayer & Louise, 2008;	Australia
	24. Caragata, 2000;	Canada
	25. P. Carey, 2000;	UK
	26. Carvalho, 2004;	Brazil
	27. Carvalho, 2008;	Brazil
	28. Carvalho & Gestaldo, 2008;	International
	29. Chang et al., 2004;	Taiwan
	30. de Vos et al., 2009;	International
	31. Ferreira & Castiel, 2009;	Brazil
	32. Flick et al., 1994;	US
	33. Geounuppakul et al., 2007;	International
	34. Guldan, 1996	Hong Kong
	35. Hawe & Shiell, 2000;	Canada
	36. Israel et al., 1994;	US
	37. Labonte, 1992;	Canada
	38. Laverack, 2006;	New Zealand
	39. Laverack, 2009;	New Zealand
	40. Lisovicz et al., 2006;	US
	41. Lopez et al., 2007;	US
	42. Lugo, 1996;	US
	43. Maton, 2008;	US
	44. McFarlane & Fehir, 1994;	US
	45. McKnight, 1985;	Canada
	46. McQuiston et al., 2001;	US
	47. Merideth, 1994;	US
	48. Östlin et al., 2009;	International
	49. Pereira, 2003;	Brazil
	50. Pratt & James, 2009;	US
	51. Rappaport, 1981;	US

Themes 2 (continuation)	References	Geographical origin of the authors
	52. Ratna & Rifkin, 2007;	International
	53. Rifkin, 2009;	UK
	54. Riger, 1993;	US
	55. Rindner, 2004;	US
	56. Rissel, 1994;	US
	57. Rudd & Comings, 1994;	US
	58. Sapag & Kawachi, 2007;	International
	59. Stang & Mittelmark, 2009;	Norway
	60. Simons-Morton & Crump, 1996;	US
	61. Tones & Green, 2004;	UK
	62. Wallerstein, 1993;	US
	63. Wallerstein & Bernstein, 1994;	US
	64. Wallerstein & Martinez, 1994;	US
	65. Wang & Burris, 1994;	International
	66. A. B. Williams et al., 2005;	US
	67. L. Williams & Labonte, 2007;	Canada
	68. Wilson et al., 2008;	US
	69. Weissberg, 1999;	US
	70. Yoo et al., 2009;	US
	71. Yoo et al., 2004;	US
	72. Zimmerman, 2000;	US
Themes 3	**References**	**Geographical origin of the authors**
Organizational empowerment strategy as a mean to address health inequities	73. Appelbaum et al., 2010;	Canada
	74. Braveman & Tarimo, 2002;	International
	75. Griffith et al., 2010;	US
	76. Gutierrez et al., 1995;	US
	77. Hughey et al., 2008;	US
	78. Itazhaki & York, 2002;	Israel
	79. Kuokkanen et al., 2009;	International
	80. Laschinger et al., 1997;	Canada
	81. Maton & Salem, 1995;	US
	82. Minkler et al., 2001;	US
	83. Peterson & Zimmerman, 2004;	US
	84. Pilisuk et al., 2005;	US
	85. Rifkin, 2003;	UK
	86. Swift & Levin, 1987;	US
	87. Wallerstein, 2006.	US

* International means a dyad or group of authors from more than one country and conference declarations.

Appendix C

Approval of the University of Western Ontario Research Ethics Board

Office of Research Ethics
The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator:
Review Number: 17379E **Review Level:** Expedited
Review Date: August 27, 2010 **Approved Local # of Participants:** 0
Protocol Title: Health promotion, organizational empowerment and health equity: a case study
Department and Institution:
Sponsor:
Ethics Approval Date: September 13, 2010 **Expiry Date:** March 31, 2011
Documents Reviewed and Approved: UWO Protocol, Letter of Information and Consent
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert
FDA Ref #: IRB 00000940

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland (jsuther@uwo.ca)	☐ Elizabeth Wambolt (ewambolt@uwo.ca)	☐ Grace Kelly (grace.kelly@uwo.ca)	☐ Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files. cc: ORE File

Appendix D

Letter of Information

Letter of Information

Title of the Research: Health Promotion, Organizational Empowerment, and Health Equity: a Case Study
Principle Investigator: Dr. Lilian Magalhães, PhD.
Student Investigator: Carolina da Paz, M.D., MSc. student.
Name of Organization: University of Western Ontario, London/ON

This letter of information is for professionals in the organization Health Nexus and who we are inviting to participate in the research. We invite you to take part in this study that will explore the concept of empowerment within health promotion organizations. This letter contains information to help you decide whether or not to participate in this study. It is important for you to understand why this study is being conducted and what it will involve. Please take the time to read over this material and feel free to ask questions if anything is unclear.

What is the purpose of this study?
Professor Lilian Magalhães, PhD, and Carolina Paz, M.D., MSc. student researcher, from the University of Western Ontario, are conducting a case study to find out more about the understanding of empowerment from the perspective of professionals working in a health promotion organization committed to address health inequities. One topic which might be discussed is: What is your understanding of the concepts of empowerment?

Why have you been contacted?
You have been asked to take part because currently you are holding a position at the organization Health Nexus which was selected to participate in this case study. There will be twelve to twenty participants at this site.

What is involved if you choose to participate?
This research will involve your participation in a focus group that will take two hours or less and will be conducted by Carolina da Paz, as part of her research trainee. The focus group will happen in a date and location to be determined. The researchers will ensure that the environment is safe and the meeting convivial. The moderator will ensure that all participants have an equal opportunity to contribute to the discussion, although you may decide not to make comments at certain times in the discussion. No compensation will be provided to the participants upon completion of the study. No one else but the people who take part in the discussion, and the researchers will be present during this discussion.

What happens to the information gathered in the study?
The entire discussion will be tape-recorded, but no one will be identified by name or position within the organization on the tape. Participants' position within the organization or names, if declared during the focus group, will be deleted during the

transcription. The tape will be kept in a locked filing cabinet in the office of the researcher. Focus group recordings will be transcribed in verbatim, and saved on a password-protected computer. All hard copies of the data will be locked in a cabinet in a secure office at the University of Western Ontario, where only the investigators will have access. The information recorded is confidential, and no one else but the study investigators will have access to the tapes. The tapes will be destroyed at the conclusion of the project. If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published without your explicit consent to the disclosure.

If you agree to participate in this project, you have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion. All information you give will be kept confidential to the extent permitted by law, and the names of all people in the study will be kept confidential by the researcher. If the results of this study are published, your name and position within the organization will not be used. Focus group members are asked to keep everything they hear confidential and not to discuss it outside of the meeting. However, we cannot guarantee that confidentiality will be maintained by group members. There are risks in taking part in focus group research and taking part assumes that you are willing to assume those risks.

Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

What are the risks and discomforts to you if you participate?
There are no known physical risks to participants from this study. Some of the topics that you will be discussing during the group discussion can be sensitive and personal. We do not want you to say anything that you might regret later and we do not want you to feel stressed by the discussion.

What are the benefits to you if you participate?
You will not get a personal benefit from participating in this study but your participation may help us get new knowledge that may benefit organization activities.

Voluntary Participation
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future employment. The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier.

Other Pertinent Information
The members of the research team are open to answer any questions you may have about the study and what you are expected to do. You will be given a copy of this form to keep. Please find the consent form attached to this letter. If you have any questions or concerns regarding this study, please contact the Principal Investigator, Dr. Lilian Magalhães. If you have any questions about your rights as a research participant or the conduct of the study you may contact The Office of Research Ethics at (519) 661-3036 or by email at ethics@uwo.ca.

Appendix E

Informed Consent

Informed Consent

Title of the Research: Health Promotion, Organizational Empowerment, and Health Equity: a Case Study

Principle Investigator: Dr. Lilian Magalhães, PhD.

Student Investigator: Carolina da Paz, M.D., MSc. student.

Name of Organization: University of Western Ontario, London/ON

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Print name of participant_____

Signature of participant _____

Date _____

Print Name of responsible for obtaining informed consent_____

Signature of responsible for obtaining informed consent_____

Date_____

Appendix F

Summary of the Analysis Sent to the Participants of the Focus Groups

Summary of the Focus Groups Interviews
April/2011

Title of the Study: Health Promotion, Organizational Empowerment, and Health Equity: a Case Study
Student Investigator: Carolina da Paz, M.D., MSc. student.

The purpose of this summary is to outline the preliminary analysis of the two focus group interviews conducted in this organization as part of a research project. The table below outlines the central themes I identified within the discussions and the components of each theme:

Themes	Components of the themes
Theme 1: Creating Empowerment	
(1) Perspectives on empowerment.	Knowledge base Sense of control Sense of inclusion Working and life experience Check out own health Appreciation Environment Hierarchical system Conscious framing Giving information
– Ideas and beliefs that affect empowerment processes.	Medicalized health promotion Universal health care Canadian culture Measurement approaches Political system Funding mandates
Theme 2: Engaging in what is important	Collective ownership Managerial structure Resilience

In what follows, I summarize each point presented in this table. Please note that to keep this document concise, I only provide a brief explanation and few examples for each theme.

As shown in the table above, I was able to identify two main themes in the focus groups. The first theme is **Creating empowerment**. Because this theme includes many components, I divided it in two parts: the first one represents the way the participants talked about their understandings of empowerment; the second part concerns ideas and beliefs that, for the participants, affect empowerment processes. The second theme, Engaging in what is important, represents how the participants' conceptualizations of empowerment are reflected in their practices.

Theme 1: Creating Empowerment

Within this theme I identified many participants' perspectives on empowerment. For example, for a staff member, the organization fosters empowerment by building a knowledge base in which the future generations of staff and board members can learn from the "*empowering experience*" of others.

Further, for some staff and board members, their understanding of empowerment entails a **sense of control** that one feels or has over him/her life and work, as well as a sense of inclusion within the workplace. However, two staff members declared that the way people is **attached to the organization** (such as in the case of a person who has a contract) is a factor that modifies people's engagement in empowerment processes because one has different assumptions about work and relationships with the colleagues.

Another factor that influences the way that the participants view empowerment is their past working and life experiences. For example, a staff member traveled to another country and was involved with popular education. Those experiences, for this person, were empowering and had a positive implication to his/her current work.

A number of staff members connect workload, and **health with empowerment. For example, a staff member** states that "*we maybe have to* **check out our health**" because "*we've been fatigued*" due to the heavy workload; for this person, the heavy workload is disempowering. In contrast, one participant says that the workload "*depends on what kind of work you do.*" Also, a staff member feels that what is empowering in the organization within the context of heavy workload is a feeling of "**appreciation and acknowledgement**" transmitted by the other members.

Some staff members link the **working environment** with the sense of empowerment. They mention some features of this empowering environment that are different from "*the other places*," such as the "*language*" used in the environment, an "*equal footing*" between the staff members, and the openness to wear "*the jeans.*" Some staff members also say that the **hierarchical system** is different from other places. For example, the participants comment that, in the organization, they are able to have a horizontal relationship with the managers.

Different from the previous conceptualizations of empowerment, a staff member articulates that empowerment may be compared to a "**conscious framing**," when, for example, the employees are told to use the same kind of terminology. However, this participant also points out that the organization "*is a very empowering place*" because "*we can manage our own schedules.*"

The board members articulate a different understanding of empowerment. For them, empowerment is about **providing information**. They argue that the organization provide "*resources, tools, consultations, facilitation, actual face-to-face contact*" and "*a lot of courses*" which are "*tools to empower the population.*" An important fact is that, for the board members, the organization "*has to make the biggest impact. And the biggest impact...is most upstream you can get to affect the most number of people.*" For the board members, the ultimate goal is to help people and communities to "*move forward*" and "*be responsible*" for their health.

So far, I have been presenting the perspectives on empowerment for the participants of the focus groups. Now, I move to the second part of the Creating of empowerment theme. This part concerns the ideas and beliefs that, for the participants, have an effect on empowerment processes.

I identified that, for some staff and board members, the "**medicalized**" approach to health promotion is what most negatively affects empowerment processes because *"people are doing programs to groups of people rather than engaging them in the issues that are important to them."* In addition, a board member argues that the current health practices are more consistent with the "*healthcare thinking as opposed to health promotion thinking.*"

Two board members also comment that the **universal health care system** fosters people to be "*engaged in the medical model*" because when "*you don't have to pay to go to the doctor than why you should be responsible for your own health?*"

The **Canadian culture** is also deemed as a way to engage people in the medical model. One board member thinks that the medical model is a "*reflection of our society, of how lazy we've become and how we just want instant gratification and instant results.*" At the same time, the board members reject the idea that the organization should work toward changing this culture when they claim that they would not include a cultural change as an organizational priority. In this individual's words, *"I wouldn't want to say, 'ok, on top of everything else you do, get out there and change the culture.'"*

Both staff and board members talk about the barriers of **measuring empowerment** activities. For them, the current measurement approaches to health promotion interventions are linked to the medical model and do not reflect the actual work of empowerment. In addition, it seems to be a tension between the organization and the funders regarding the measurement of the organization's activities, since the funders require a specific way to measure these activities, while the organization thinks other approaches are more appropriate to assess the organization's outcomes.

The board members also argue that the **political system** affects the health promotion and empowerment activities because the politicians are not "*willing to hear*" stories about "*how health promotion has made difference within aboriginal communities, for example.*" Another board member believes that the politicians "*just do the job, they don't go in depth, they don't analyze really the impact of health promotion versus treating patients.*" As a result, the organization should "*lead by example*" and "*influence public policy to be healthy public policy*" through "*collective action.*"

For both staff and board members, the organization's **funding mandate** also influences the organization. As a board member puts it, "*I think when you're using public money, you have to, there always has to be a balance. You don't want to do a revolution and lose all your funding. You have to work within your funding mandate.*"

Theme 2: Engaging in what is important.

Within this theme, I present the participants' ideas on how the organization puts in practice what they think is important for the organization itself, the clients, and the system as whole.

The staff members agree that "**collective ownership**" is very important for the empowerment process within the organization because the staff "*can shape together*" the organization activities and the challenges that likely will come.

For the staff members, the **managerial structure** of the organization is also linked with empowerment processes within the organization. When talking about the relationship between managers and other staffs, a staff member provide a collective view ("*I think we all played a part in creating something that was different*"). In contrast, other staff member believes the working environment "*all depend of the management.*"

The participants of the staff focus group also articulate their **resilience**, their ability to "*ride what's coming out.*" For the participants, this sense of resilience is present in the organization's activities and affects the sense of empowerment. However, one staff member questions the fact that this resilience is spread in all parts of the organization: "*I just find it would just be interesting to find that part of us that doesn't feel the empowerment or doesn't feel resilient.*" For this participant, this would bring a different view of the empowerment processes within the organization.

Conclusion

This document is an attempt to summarize the discussion occurred during the focus group in which you have participated. It provides just a glance of the overall analysis, but it is thorough enough to give you a sense of the most important aspect that I was able to identify in the focus groups. Please note that in the full thesis write-up, I will provide more explanations about the themes presented here.

I hope I was able to capture the main points of our discussions. Now, I would like to hear your thoughts on this preliminary material. I would encourage you to provide your feedback in various ways:

- Group conversation: I would like to know your availability to be part of a group conversation about this document. To that end, I created the following Doodle pool to see the possibility of this encounter: (URL)

- Online conversation: You can write your thoughts and email it to all participants of the focus groups. You can choose the way you will write your comments; it can be within the document (please, mark your comments in a different color), or in the body of an email.

- Individual feedback: If you want to provide an individual feedback just for the researchers, you can email me or schedule a telephone or in person conversation. In that case the conversation will be taped and transcribed verbatim.

Any additions or corrections will be included in the next step of the data analysis. Please feel free to provide your feedback in any way you want. Similar to your

participation in the focus group, it is up to you to decide if you want to participate in this feedback process. All the comments are very welcome and appreciated. I would like to hear back from you until the May 24th, 2011, when the next phase of the data analysis will begin.

Thank you again for your participation in the study.

Appendix G

Samples of the Diagrams that Assisted in the Data Analysis

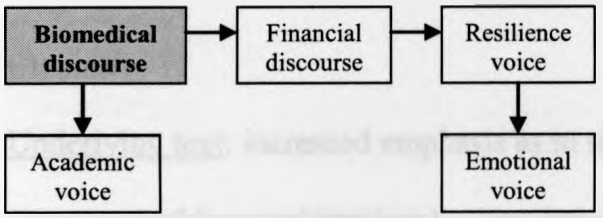


Diagram 1. Annual reports: Preventing diseases – discourses and voices.

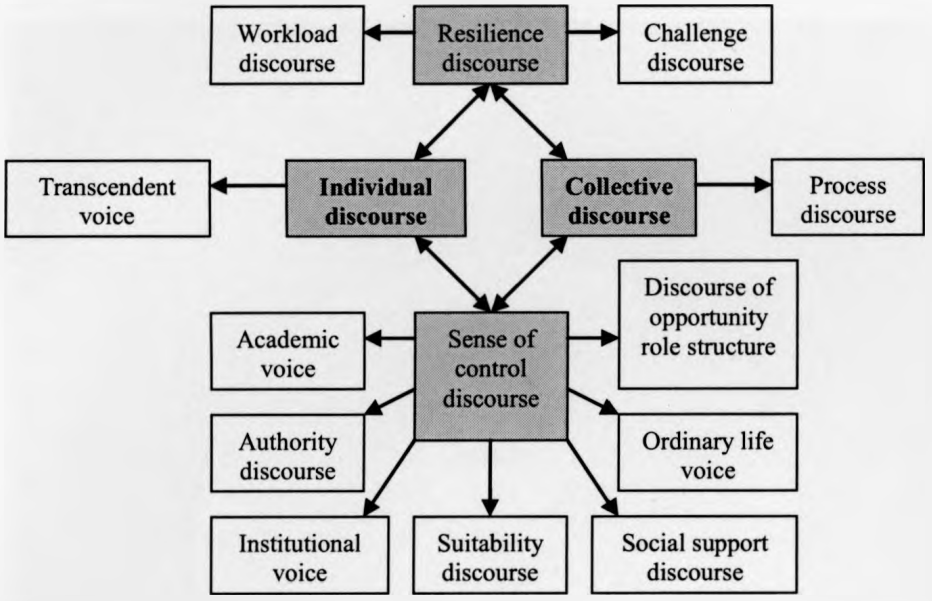


Diagram 2. Staff members' focus group: Views on empowerment – discourses, and voices.

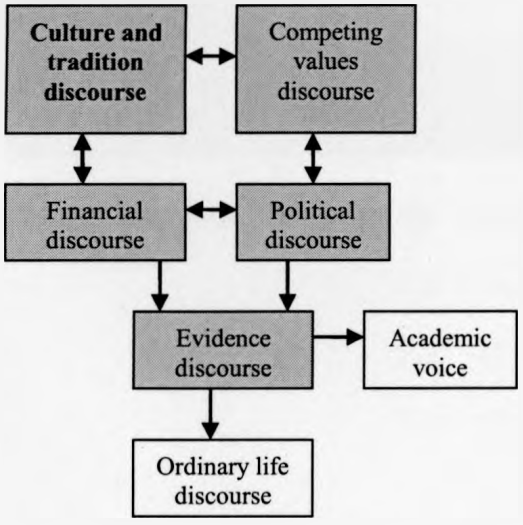


Diagram 3. Board members' focus group: Engaging in what is important – discourses and voices.

Appendix H

Transcription Signals as Recommended by Sarangi (2010)

(.): pause

Underlying text: increased emphasis as in stress

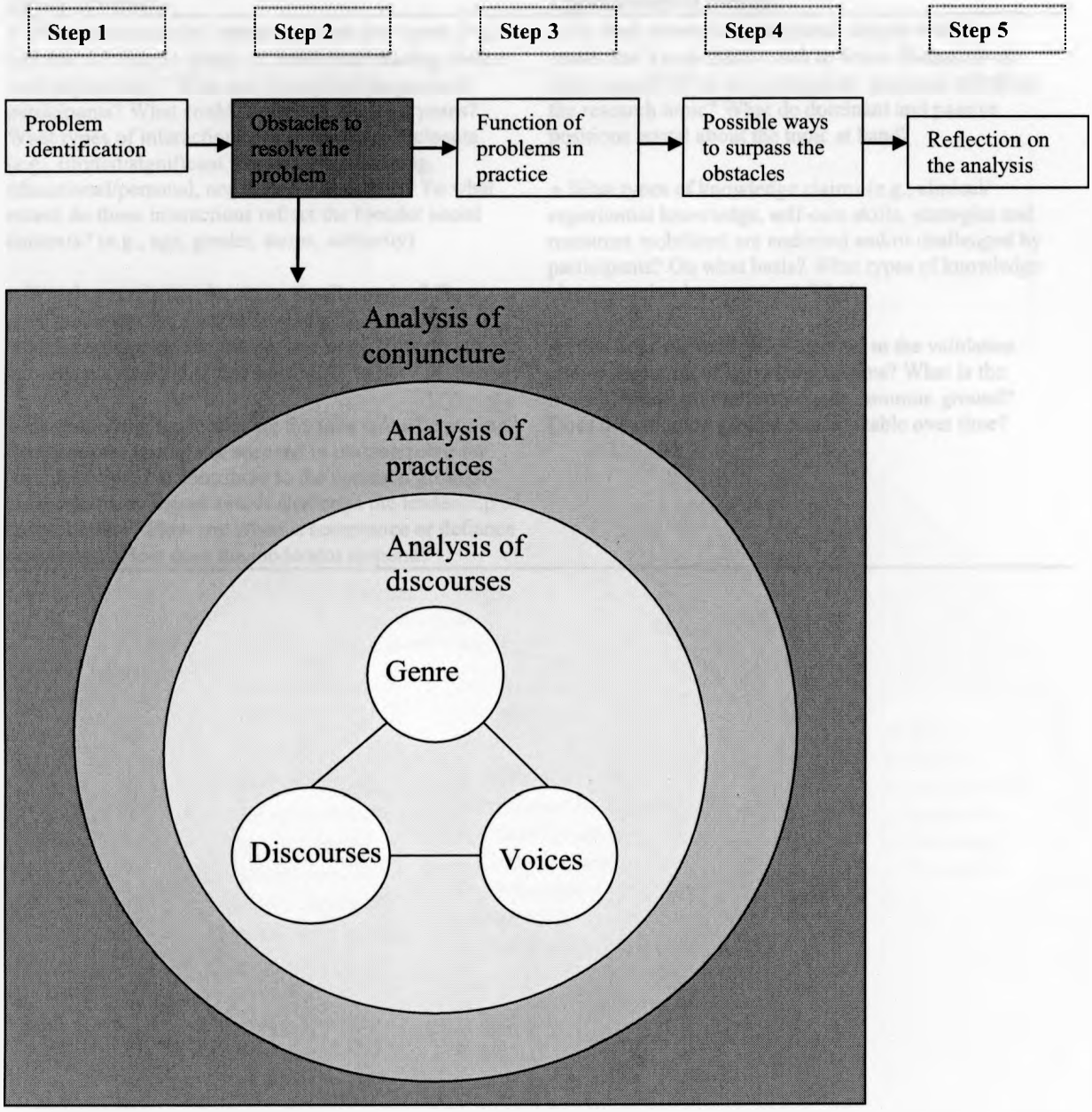
((text in double round brackets)): description or anonymized information

(text in round brackets): transcriber's guess

(…): omitted text to enhance clarification

Appendix I

Visual Representation of the Chouliaraki and Fairclough (1999) Critical Discourse Analysis Framework



Note: This figure represents the five steps of the framework and the sub-steps of the second step.

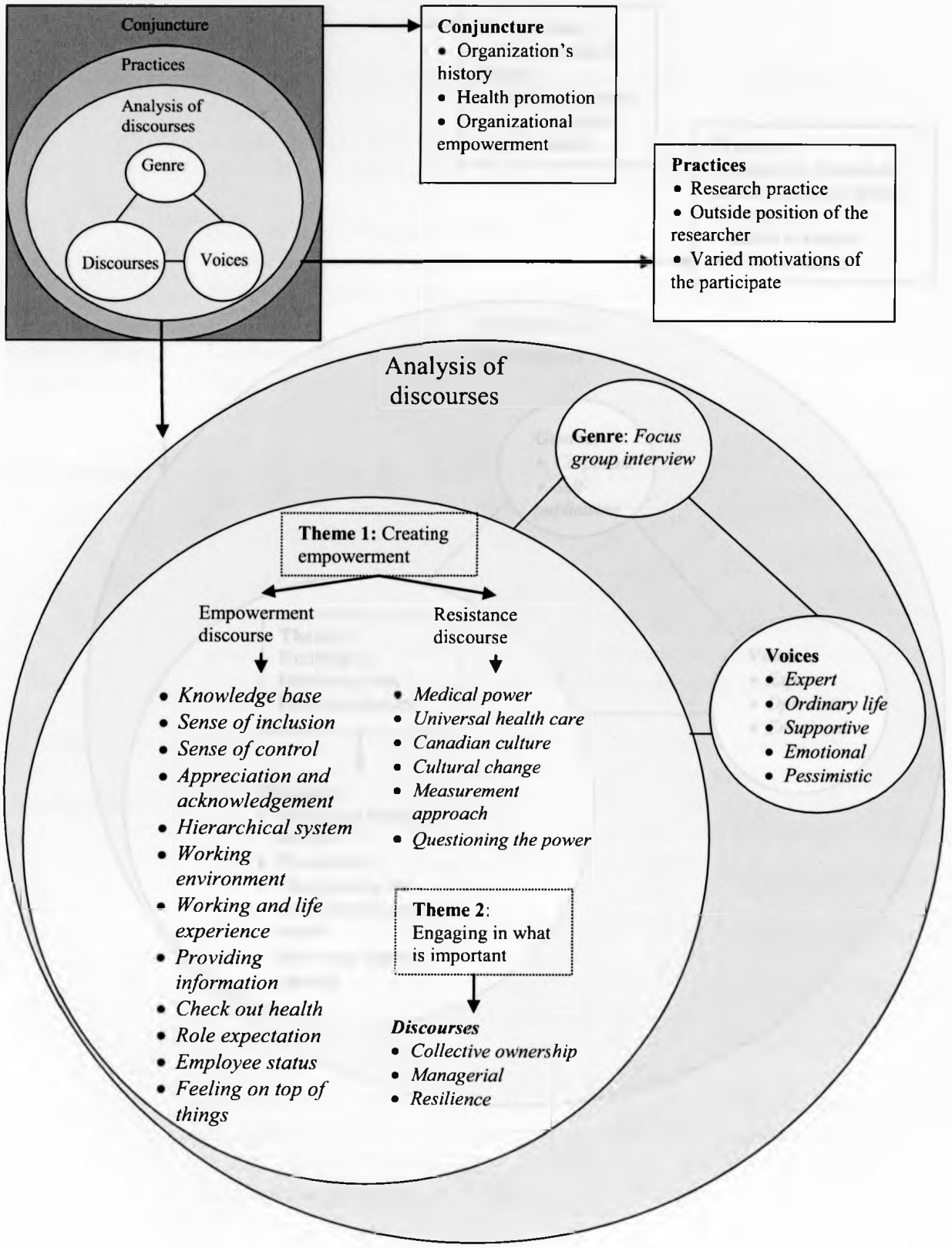
Appendix J

Analytical Template for Focus Group Research Adapted from Lehoux, Poland, & Daudelin (2006)

Group processes	Epistemological content
• Who do participants represent when they speak (e.g., member of a larger group, an individual sharing his/her own experience)? What are the explicit purposes of participants? What could be their implicit purposes? What types of interactions occur among participants (e.g., limited/significant, empathic/challenging, educational/personal, negative/constructive)? To what extent do these interactions reflect the broader social contexts? (e.g., age, gender, status, authority) • Which participants dominate the discussion? How does this affect the contribution of other participants? Which participants adopt a passive role? How do other participants respond to this position? • How does the moderator set the tone at the beginning? How does the moderator succeed in making room for each participant to contribute to the common ground? Do participants accept and/or challenge the leadership of the moderator? How and when is acceptance or defiance manifested? How does the moderator respond?	• To what extent do participants comply with the moderator's cues and/or seek to foster discussion on other issues? What do participants' purposes tell about the research topic? What do dominant and passive positions reveal about the topic at hand? • What types of knowledge claims (e.g., clinical/ experiential knowledge, self-care skills, strategies and resources mobilized are endorsed and/or challenged by participants? On what basis? What types of knowledge claims receive less support? Why? • How does the moderator respond to the validation and/or disputing of knowledge claims? What is the overall impact on the focus group common ground? Does the common ground remain stable over time?

Appendix K

Summary of the Themes, Discourses and Voices of the Focus Groups and their Relation to the Second Step of the Critical Discourse Analysis Framework



Appendix L

Summary of the Themes, Discourses and Voices of the Annual Reports and their Relation to the Second Step of the Critical Discourse Analysis Framework